THE CANADIAN NURSE

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The views expressed in the various articles are the views of the authors and do not necessarily represent the policy or views of The Canadian Nurse *nor of the Canadian Nurses' Association.*

Executive Director and Editor: Margaret E. Kerr, M.A., R.N.
Associate Editor: Jean E. MacGregor, B.N., R.N.
Assistant Editors: Gabrielle D. Côté, M.A., R.N., Pamela E. Poole, B.N., R.N.
Production Assistant: Elizabeth M. Hanlon. *Translator:* Lily Tasso.
Circulation Manager: Winnifred MacLean
1522 Sherbrooke Street West, Montreal 25, Quebec

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Between Ourselves

Journeying across the province of Saskatchewan in the dome of the *Canadian* or motoring along the TransCanada highway, a traveler is aware of the treeless expanse of flat prairie, dotted here and there by tiny ponds that reflect the very blue sky above. The horizon stretches away for fifty miles, at least, in every direction. Depending on the season, the fields will be green, golden or snow covered. This is the bread basket of Canada for Saskatchewan ranks first among the provinces in the production of wheat, oats and flax.

The traveler who ventures away from the southern routes will find a different landscape. The countryside north and east of Prince Albert is heavily timbered with tamarack, spruce and jack pine. Gently rolling hills and broad fertile valleys present a more familiar landscape to those from other parts of our country. There, in the little town of Speers, not far from North Battleford, our guest editor, ELEANORE LOUISE MINER, was born. Though she went to Royal Alexandra Hospital in Edmonton for her nursing education and roved farther afield in her early professional practice, since 1945 Miss Miner has engaged in public health nursing in her native province. She is presently one of the consultants with the Provincial Department of Health.

The Saskatchewan Registered Nurses' Association is justly proud of the splendid new building that is now its home in Regina. President of the SRNA since May, 1959, Miss Miner was chairman of the Building Committee during the very busy days of planning and construction.

* * *

Three of the articles that won prizes in this year's Macmillan Award competition are included in this issue. Nurses in Edmonton, Alberta, may take special pride in the fact that all three of these student authors are receiving their education in schools of nursing in that city. We congratulate these youngsters and wish them well in their chosen profession.

Three other comprehensive nursing care studies that were also awarded prizes will be published in subsequent issues.

* * *

Most human beings treasure the hope that their advancing years may be spent in happiness and contentment. To achieve this goal they need only two things — economic security and freedom to do as they please. Yet, how many old people are acutely discontented and unhappy because well-meaning relatives and friends try to "take charge of them"? They may reach a state of boredom when neither medical science nor good nursing care can be of assistance. It is important, therefore, that every nurse should know not only how to care for the aged when they are ill but also be aware of this basic concept of geriatrics: *old age can be satisfying*. It need not, should not, be simply a period of idly sitting and waiting for the inevitable death.

We were delighted recently by a glimpse of an old lady of 94, who, spry as a cricket, was standing on a ladder making some necessary repairs to a rose trellis. Her daughter, aged 72, was not sure-footed enough to climb the ladder so she was busy trimming the borders of the flower beds.

Volumes have been written on gerontology. The series of articles included in this issue can touch on only a tiny sector of this topic. The nurse who takes the trouble to know her aged patients as the individuals they are may often benefit from a philosophy of life that only the passing of years can bestow.

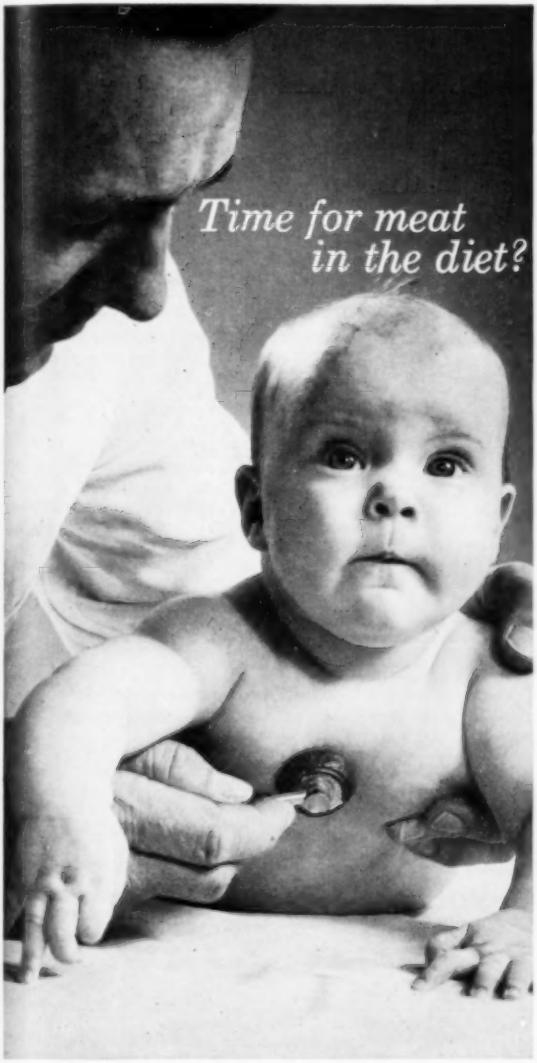
* * *

Some months ago we stated in the *Journal* that the mouth-to-mouth method of artificial respiration had not yet been approved as a useful technique by the Canadian Red Cross Society. Believing that there are frequent occasions when it is particularly effective, we are pleased to note that the central council of the Society has recently adopted a resolution to include this method in the instruction given to their first aid classes.

* * *

It has been our custom to include our day-by-day report of the biennial meetings of the Canadian Nurses' Association in the August issue of *The Canadian Nurse*. To meet our deadline dates, it has been necessary to postpone the publication of the story until the September issue. Watch for it then.

An awareness of team nursing is not confined to the nursing staff of the Montreal Children's Hospital. Recently a very young patient asked the nurse, "Am I on your team?" Following a positive reply, he queried further, "Who's winning?"



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Indications—Any dry, pruritic skin condition where the area is too extensive to treat with usual emollient preparations, e.g., contact dermatitis, chronic atopic dermatitis, psoriasis, soap dermatitis, etc.

Description—Antipruritic bath oil containing, in emulsified form, a fraction of lanolin, mineral oil and a non-ionic emulsifier.

Administration—May be used in the bath (½ to 1 oz.), in the shower (apply with wet sponge to body), as a sponge bath, or applied directly to the skin.

Manufacturer—Westwood Pharmaceuticals. *Canadian Distributor:* John A. Huston Company, Limited, Toronto 10.

BAMADEX

Indications—Adjunct in management of obesity, especially in the patient with emotional problems.

Description—Each tablet contains: d-amphetamine sulfate 5 mg., meprobamate 400 mg.

Administration—Usual dosage: one tablet t.i.d. ½ to 1 hour before meals.

Manufacturer—Lederle Laboratories, 5550 Royalmount Avenue, Montreal 16.

CAYTINE AND CAYTINE WITH PHENOBARBITAL

Indications—Asthma, emphysema, chronic bronchitis, bronchiectasis, pulmonary fibrosis. Can be used for long-term management of chronic broncho-constrictive disorders as well as for rapid relief in acute attacks.

Description—Alpha [(alpha-methyl-3, 4-methylenedioxyphenethylamino)-methyl]-protocatechuyl alcohol hydrochloride, a bronchodilator effective orally, parenterally and by inhalation.

Administration—Tablets: 1 or 2 t.i.d. with meals and at bedtime with food. Injection or inhalation: for use in acute seizures.

With phenobarbital—32 mg. tablets. Inhalation: 1:100, in 10 cc. bottles. Injection: (i.m. or s.c.) 0.5 mg. per cc.

Manufacturer—Lakeside Laboratories (Canada) Ltd., 24 Wellington St. West, Toronto.

DARENTHIN

Indications—Hypertension.

Contra-indicated in pheochromocytoma and recent myocardial infarction. Should be used with caution in marked cerebral and coronary arteriosclerosis.

Description—Each tablet contains 200 mg. bretylium tosylate (N-o-bromobenzyl-N-ethyl-N: N-dimethylammonium p-toluenesulfonate), hypotensive agent acting by selective block at postganglionic sympathetic fibres.

Administration—Dosage individualized. Suggested initial dose is 200 mg. t.i.d.; may be increased by adding 100 mg. daily to the dose each day until the desired effect is achieved. Average daily dose is about 1 gm.

Effect may be enhanced by diuretics, such as chlorothiazide, or hypotensive agents, such as reserpine.

Manufacturer—Burroughs Wellcome & Co. (Canada) Ltd., Montreal 32.

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Description—Disposable cotton garment at a price that is below the cost of laundering. Hangs 44" from shoulder to below knee length. Price 15 cents.

Manufacturer—Busse Hospital Products, 64 E. 8 St., New York 3, N.Y.

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Description—Patterned after human milk, is made from nonfat milk, lactose, oleo, corn and coconut oils, and soy lecithin, with added vitamins and minerals.

Caloric distribution consists of 9% from protein, 50% from fat and 41% from carbohydrate as compared with 7%, 51% and 42% respectively in average human milk. Curd tension is practically zero.

Administration—Mix with water, bottle and feed. Normal dilution — 1 level measure to 2 oz. water, or 1 level measuring cup to 32 oz. of water; supplies 20 calories/fl. oz. Measuring scoop supplied.

Manufacturer—Mead Johnson of Canada Ltd., Belleville, Ontario.

FULVICIN

Indications—An antifungal antibiotic orally effective against ringworm of the scalp, beard, body, hands, feet, fingernails and toenails.

Description—Each tablet contains 250 mg. of griseofulvin.

Manufacturer—Schering Corporation Limited, Montreal 9.

The Journal *presents pharmaceuticals for information. Nurses understand that only a physician may prescribe.*

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For further information write to:

DIRECTOR, McGILL SCHOOL FOR GRADUATE NURSES,
1266 PINE AVE. W., MONTREAL 25, QUEBEC.

GRIFULVIN

Indications—For oral use in treatment of ringworm of the scalp, body or nails, athlete's foot.

Description—Each tablet contains: griseofulvin 250 mg., oral antifungal agent.

Administration—Adults: 4 tablets (1 gm.) daily. Children: 30 to 50 lbs., 1-2 tablets daily; over 50 lbs., 2-4 tablets daily.

Manufacturer—McNeil Laboratories of Canada Limited, Toronto 2B.

GRISEOFULVIN

Indications—Fungus infections of the skin, hair, and nails (e.g. ringworm, onychomycosis,* etc.) which do not respond to topical therapy.

Description—Each tablet contains 250 mg. griseofulvin, an oral fungistatic obtained from several species of penicillium. Nontoxic clinically and any side effects (rarely reported) are mild and transient in character. Penicillin-sensitive patients do not appear to develop reactions to the drug, and the development of resistance has not been encountered.

Administration—Adults: 4 tablets daily or as prescribed; children: 1 to 2 tablets daily.

Manufacturer—Ayerst, McKenna & Harrison Limited, P.O. Box 6115, Montreal.

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Administration—Children: 10 to 25 pounds, 5 mg. per pound of body weight q.6 h.; 25 to 50 pounds, 1 teaspoonful q.6 h.; over 50 pounds, 2 teaspoonfuls q.6 h. Adults: 2 teaspoonfuls q.6 h. In more severe infections, these dosages may be doubled.

Manufacturer—Eli Lilly and Company (Canada) Limited, P.O. Box 4037, Terminal "A," Toronto 1.

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When mixed as directed, each 5 cc. (approximately one teaspoonful) will contain: erythromycin base 125 mg., sulfadiazine 167 mg., sulfamerazine 167 mg., sulfamethazine 167 mg., aromatics, q.s.

Administration—Usual dosage: children: 10 to 25 pounds, ½ teaspoonful q.6 h.; 25 to 50 pounds, 1 teaspoonful q.6 h.; over 50 pounds, 2 teaspoonfuls q.6 h. Adults: 2 teaspoonfuls q.6 h.

Manufacturer—Eli Lilly and Company (Canada) Limited, P.O. Box 4037, Terminal "A," Toronto 1.

WILLCOBARB

Indications—Hypnotic and sedative in insomnia, nervous exhaustion, hysteria, neurasthenia and anxiety states.

Description—Each capsule contains: secobarbital sodium 50 mg., butabarbital sodium 50 mg.

Administration—One as prescribed.

Manufacturer—Charles R. Will & Co Ltd., P.O. Box 444, London, Ont.

The Journal *presents pharmaceuticals for information. Nurses understand that only a physician may prescribe.*

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N.B.: The School of Nursing also offers, for high school graduates with University Entrance, a *Basic Professional Course* leading to the degree of B.S.N.

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1560 EST, SHERBROOKE,
MONTREAL, QUEBEC.**

Random Comments

Dear Editor:

I would like to take this opportunity to thank you for such an excellent magazine. As I am no longer active in nursing, it gives me a very good opportunity to keep up with the new trends. I especially enjoyed the mental health series, and the nursing care studies are most interesting.

M. E. M., Ontario

Dear Editor:

Please accept my congratulations for the work you are doing in producing a magazine of the quality of our *Canadian Nurse.*

A. H. M., Nova Scotia

Dear Editor:

I enjoy reading the *Journal.* Sometime in the future would you please feature "Intensive Care Unit." It is an apparently very new way of providing specialized care to very ill patients. Patients would have to rely less on private duty nurses. It is separate and apart from the postoperative recovery room.

If some, who have experienced this new setup, would write about it and share it with the rest of us, it would be appreciated.

B. J. F., New Brunswick

¶*A request has been made to have the supervisor of such a unit prepare an article on this subject. It will appear in a future issue of the Journal.* Ed.

Dear Editor:

I am writing to thank you for the article "The Greatest of These" which appeared in the March issue of *The Canadian Nurse.*

I am an older nurse, trained in the 1920's, but working in an active labor and delivery room. I still believe we are there to look after the patient and that is our primary purpose. When we went in training our ambition was to nurse sick people not write reams of paper.

Thank you again. We need a few more articles like it and put them in a prominent place.

D. S., Ontario

¶*This article was originally published in R.N. and reprinted in the ICN Review.* Ed.

Dear Editor:

I often think of Canada and the University of Toronto from which I graduated in

1930. Montreal, too, brings back memories of the ICN congress held there in 1929. The city was so beautiful.

I am so grateful to a Canadian nurse for sending me a copy of the *Canadian Nurse*. I wish I could pay for it but I cannot have Canadian money.

I am working in the largest hospital in Korea. It is a combined project of the Scandinavian and Korean governments with the aid of UNKRA. It has a three-year school of nursing with entrance requirements and standards very similar to those of Canadian schools.

My best wishes to the *Journal* and the Canadian Nurses' Association.

FRANCES L. WHANG
Seoul, Korea

MEMORIAL BURSARY

St. John Ambulance recently announced the establishment of a bursary fund in memory of the late Countess Mountbatten of Burma, Superintendent-in-Chief of the St. John Ambulance Brigade in the Commonwealth and Vice-President of the Royal College of Nursing. This fund is to be used as bursary assistance in nursing. The first award will be available in September, 1960. At the outset, first consideration will be given to an applicant identified with the St. John Ambulance.

For details apply to the Chairman, The Countess Mountbatten Bursary Fund, St. John Ambulance Headquarters, 321 Chapel Street, Ottawa 2, Canada.

* * *

£1,000 has been donated by the Royal College of Nursing in Great Britain to assist in the organization of nurses for relief work being undertaken by the British Red Cross Society, in the recently devastated areas of Mauritius and Morocco.

The money comes from a special fund, held by the Royal College of Nursing, for organizing trained nurses to assist in relief work abroad.

* * *

We have a comparatively decent system of common schools, schools for children only, but no schools for ourselves. It is time that we had uncommon schools, that we did not leave off our education when we begin to be men and women.

— HENRY THOREAU, 1854

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III. Diploma Course in Public Health Nursing.

IV. Diploma Course in Teaching and Supervision in Schools of Nursing.

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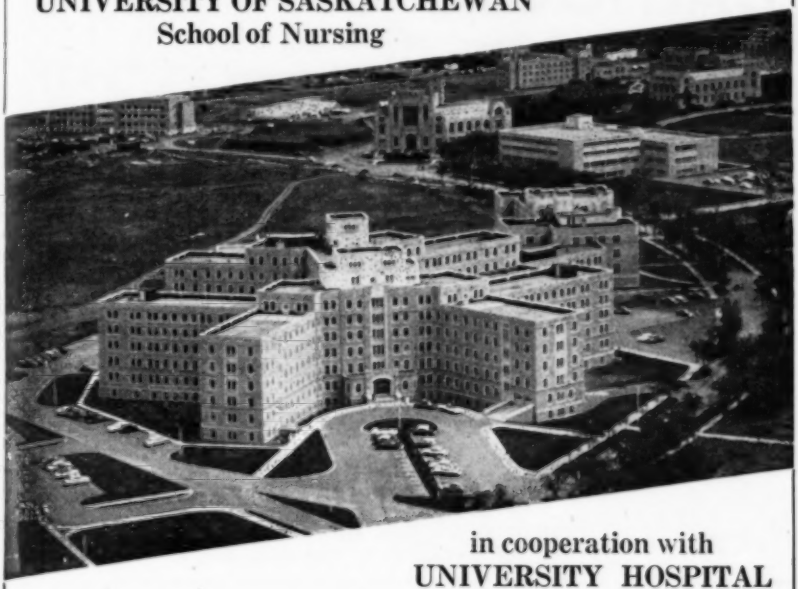
Director of Nurses,
Wills Eye Hospital,
1601 Spring Garden Street,
Philadelphia 30, Penna.

UNIVERSITY OF SASKATCHEWAN
School of Nursing



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For further information or inquiries about scholarships, write to:

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   (b) Teaching in Schools of Nursing
   (c) Nursing Service Administration

For further information apply to:

DIRECTOR, SCHOOL OF NURSING
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N.B. For specialization in obstetrics and pediatrics, bursaries, distributed by the Marguerite d'Youville Institute, are offered to the nurses of the province, by the divisions of Nutrition, and Maternal and Child Care of the Ministry of Health of the Province of Quebec.

Ability to speak French essential.

For further information, write to:

LA DIRECTRICE
INSTITUT MARGUERITE D'YOUVILLE
1185 RUE ST-MATHIEU - MONTREAL 25, P.Q.
TEL. WE. 7-9501 - LOCAL 43

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VIGOROUS GROWTH

THE SASKATCHEWAN Graduate Nurses' Association was formed in 1911. On April 24, 1917, forty-three years ago, the first recorded meeting of the Saskatchewan Registered Nurses' Association was held, with Miss Jean Browne as president and Miss Jean S. Wilson as secretary. The full council, named later in the year, was comprised of six nurses and two physicians.

Office space was located "under the bed" of the voluntary secretary-registrar, to accommodate files of the 99 members. The first convention of the SRNA was held in 1918 in accordance with the Act respecting the Association that was passed in 1917. Saskatchewan was the second province to pass such an Act. The first annual meeting recorded a resolution favoring "the support of nursing as a permanently important and satisfying profession."

Devoted nurses worked hard to foster the growth of the Association. A part-time secretary-treasurer was employed in 1920 and by 1922 office space was provided by the Red Cross Society in Regina. The office was later housed in the Institute for the Blind in Regina, and by 1925, 168 members were financing a $10.00 monthly rental. Records show that office quarters were moved three more times in Regina before being transferred to the University of Saskatchewan in Saskatoon in 1938. Miss Kathleen W. Ellis became

(West's Studio)

LOUISE MINER

part-time secretary-treasurer-registrar in 1937 and was active in that position until 1950.

A travelling instructor was appointed in 1943. This position, now that of adviser to schools of nursing, has recently been part-time. Ways and means are under study to make this a full-time position again.

The first assistant registrar was appointed in 1947. Membership had increased to 2160 in 1950. At that time Miss Lola Wilson was appointed the first full-time secretary-treasurer-registrar. She took the title of executive secretary-treasurer in 1956 when Miss Grace Motta was appointed the first full-time registrar.

The office was moved back to Regina in 1950; floor space was increased in 1952 and again in 1956.

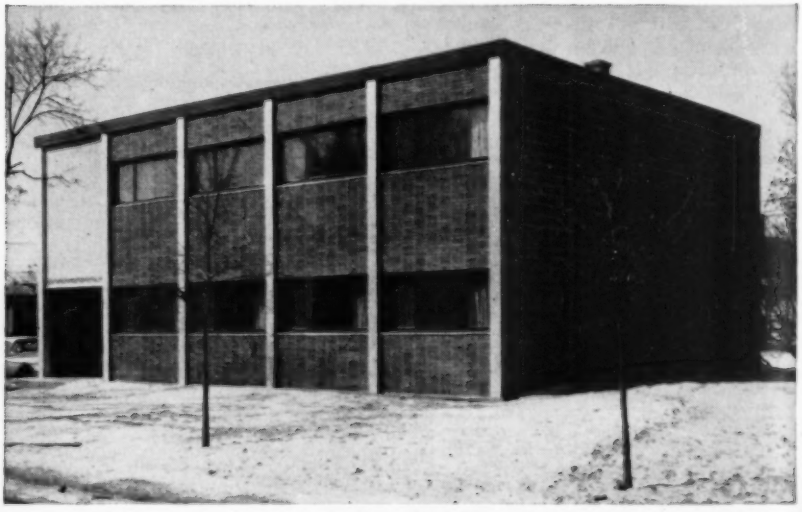
The SRNA Act was amended in 1955 to include nursing assistants and provision was made for their certification in 1957. The organization meeting of the Saskatchewan Nursing Assistants' Association was held in 1958.

The work of the executive-secretary, registrar and four member office staff and of Council continued to increase. By 1959 registered nurses' membership numbered 3738 and certified nursing assistants 510.

The finances of the SRNA had been in capable hands. More recent members owe a great deal to former members, who are largely responsible for the favorable bank balance that allowed for consideration of the construction of an office building for the Association.

The May, 1958 annual meeting passed the motion that "the council be empowered to proceed with the selection of a suitable building for the SRNA headquarters and that they appoint a Building Committee which would advise and help in this project." A twelve-member committee was formed and began work immediately. A concerted six-week effort followed, contacting all real estate companies in Regina, making over a hundred telephone calls and assessing 20 sites before papers were signed for the purchase of a 65′ x 125′ lot and a two-storey frame house at 2066 Retallack Street. The house was sold and moved. During the 18 months following the decision to build, nine meetings of the full committee and numerous subcommittee meetings were held before the offices of the SRNA, after 43 years of wandering, found their own home on November 26, 1959.

"Home" is a two-storey building with full basement 52′ x 40′ in size. The front is of buff brick with the sides and back of concrete block in a matching color. An additional storey may be added if necessary and facilities are provided to allow for the installa-



S.R.N.A. Building

tion of air conditioning at a later date, if required. An "intercom" system connects the front office with two private offices and the conference room. The main flooring is of tan vinyl tile.

The building faces east. On entering, you find a beautiful SRNA crest in gold, maroon and white in the centre of the tan-colored terazzo floor (courtesy of Antonini and Sons who laid the flooring). One buff brick waiting room wall has a brass wall-clock. Facing you is a mahogany wall, an attractive planter lighted by hanging brass light fixtures, and a green stair-well with terazzo stairs. Pretty moss green upholstered mahogany furnishings make this one of our favorite corners. To the right is a sunshine yellow general office with a pumpkin-color topped mahogany reception counter and additional work counter space under the west window. A mimeograph room in green and cocoa, and a vault, open off the general office. A folding mahogany door permits the locking of the entire office area. Private offices face east, two in yellow and two in green with walnut office furnishings.

Sliding doors are used in the hall bookcase, private offices, lounge, kitchen and locker room to conserve floor space.

The conference room and lounge on the second floor have an east wall in blue with attractive interlined drapes that will be useful for film projection. Two walls of the conference room are in beautiful walnut panelling with central folding areas covering chalk boards. The two doors to the conference room are also in walnut. One folding walnut door separates the conference room from the lounge and another will divide the conference room. Brown, turquoise and gold upholstered walnut lounge furniture, walnut tables and podium, and tan Fiberglas stack chairs furnish these rooms. A small blush-colored kitchen with double sink, stove and refrigerator adjoins the conference room and lounge. The locker room is painted cream, the cloak area is a blush shade, and the washrooms are a moss green with pumpkin-colored counter tops. Adjustable steel shelves provide for basement storage. An adequate parking area is hard-surfaced.

S.R.N.A. Waiting Room

Growth and development — from office space under a bed to a $100,000 investment of building and property, entirely paid for by a beginning nurse membership of 99, reduced to 41 in 1922, then steadily increased to the present figure. Twelve chapters of registered nurses and four of nursing assistants are now active in the province.

Saskatchewan registered nurses are proud of their heritage and humble in the knowledge of the debt they owe the pioneers and the long standing members of their Association. To whom much has been given — from them more shall be expected. Our building accommodated 44 meetings in the first three months of this year. Tribute is due present and past executive secretaries, registrars and office staffs. Association members sincerely hope that our office building may be wisely and effectively used, in keeping with the resolution of its first annual convention: "in the support of nursing as a permanently important and satisfying profession."

LOUISE MINER,
President,
Saskatchewan Registered Nurses' Association

A survey of 127 companies revealed that 69% employed known diabetics. Regarding the companies' "experience as to reliability and absenteeism," 51% felt it to be satisfactory and 47% claimed it to be "same as average worker." — *Occupational Health Bulletin*

Mental Diseases of Old Age

JOHN GIBSON, M.B., CH.B., D.P.M.

One of the very disturbing aspects in the care of the elderly may be their tendency to undergo regressive personality changes. It is very hard for the family to watch an alert, intelligent, independent member become forgetful, disoriented, incoherent, irritable and unhappy. Why do such changes occur? What are the chances for control or cure?

THE COMMONEST mental diseases of old age are senile dementia, arteriosclerotic dementia, depressive and manic illnesses, paranoid states, and confusional states.

Senile Dementia

Senile dementia does not usually begin before the age of 60. More women are affected than men. The brain shows atrophy and a generalized disappearance of brain cells. The cause of this change is unknown but hereditary factors probably play a part in its production.

Common symptoms are: a decline in intelligence, emotional disturbances and apathy, proceeding to a severe disorganization of the personality. The earliest symptom is a loss of memory for recent events, while memory for remote events, such as those of childhood, may remain good. The common emotional expressions are irritability and peevishness. Paranoid delusions are likely to develop and the patient may make accusations of theft and poisoning. Insomnia and restlessness are common. The patient wanders about, gets up in the middle of the night, shouts out of the windows, turns on gas taps, wanders into the street. Control of the sphincters is lost early. Speech is wandering and irrelevant and degenerates to a babble of meaningless sounds. Once begun the disease progresses to profound dementia. A fracture or acute physical illness may precipitate an acute confusional attack. Admission into hospital often produces rapid deterioration; about half the patients admitted die within six months.

Dr. Gibson is a psychiatrist at St. Lawrence's Hospital, Caterham, Surrey, England. This is the eighth of a series of articles on psychiatric subjects.

Arteriosclerotic Dementia

This is due to cerebral arteriosclerosis either alone or associated with hypertension, the clinical picture of the two conditions being slightly different. More men are affected than women, and the illness begins at an earlier age than senile dementia.

Cerebral arteriosclerosis produces an impairment of memory for recent events, a reduction of intelligence and ability, a narrowing of interests, and an inability to grasp new situations. Unlike senile dementia this condition produces little change at first in the personality of the patient, who may be aware of his deterioration and respond to it with anxiety and depression. Parkinsonism and epileptic attacks that may be major, minor or Jacksonian in nature, may occur. Hypertensive patients are likely to suffer headaches, giddiness, unsteadiness and blackouts. Insomnia and nightmares produce restlessness and anxiety. The patient becomes irritable and unhappy, and is apt to vent his unhappiness on others. Acute confusional states, lasting from a few hours to a few days, in which the patient is confused, disoriented, deluded and hallucinated may occur. He may die in such an attack or survive to suffer more. Attacks of hypertensive encephalopathy may occur. These produce a sharp rise in blood pressure, vomiting, blindness, epileptic attacks and paralysis. The attacks last for several hours and leave the patient partially paralyzed. With each exacerbation of the illness deterioration takes place, until pneumonia, heart failure or a cerebral hemorrhage closes the scene.

The treatment of the hypertensive patient is essentially medical, with appropriate drugs and a readjustment of his way of life to his disability.

With the development of severe mental changes, admission into a mental hospital becomes necessary.

Depressive and Manic Illnesses

These may occur in the elderly as in younger people. Some have their first attack after the age of 60. Attacks of depression are much commoner than attacks of mania. They may appear as typical attacks of the manic-depressive variety, with depression and retardation as predominating features. They may take the form of an involutional melancholia, with depression, anxiety, agitation, paranoid ideas, and nihilistic delusions. They may appear as a "neurosis," with anxiety, insomnia, and preoccupation with bodily functions, such as the state of the bowels. Depression in old age may be precipitated by retirement, bereavement, poverty and loneliness. Suicide is common.

Attacks of mania are very similar to those of earlier life, with a sudden onset — flight of ideas, delusions of wealth and physical or sexual prowess — and often a sudden termination. In some the mania continues as a chronic state.

The prognosis for the majority of these attacks is good. Treatment follows the usual lines for depressive and manic illnesses. Old age is not *per se* a bar to ECT.

Paranoid States

Paranoid states developing for the first time in old people are more common in women than men. They are often associated with some degree of blindness or deafness. The condition closely resembles paraphrenia of middle age. Typical delusions are those of persecution. The patient believes that he is being poisoned, that he is being subjected to rays projected on to him by police or malign neighbors, that slanderous reports are being circulated about him by word of mouth or in the newspapers. He is likely to be noisy, abusive and threatening, or may barricade himself in his room. He is completely without insight. He retains his personality, habits and appearance in all matters not affected by his delusional ideas. Admission to a mental hospital becomes necessary when his behavior becomes abnormal. He regards this as part of the plot against him. The patient usually remains deluded for the rest of his life.

Confusional States

Such acute states are common in old age. They may be precipitated by organic disease of the brain, such as cerebral arteriosclerosis and cerebral tumor; by pneumonia, acute bronchitis, or other infection; by heart failure; by surgical operations, especially prostatectomy and removal of cataracts. They may be associated with gross vitamin deficiency in the diet, especially when an old man lives alone in poverty. During an attack the patient is restless, confused, disoriented, hallucinated. He does not sleep, takes little or no food, and may become dehydrated. The death rate is high, but recovery is possible. A few patients are left demented. Treatment is admission to hospital, the administration of food and drink (tube feeding is usually necessary), the provision of an adequate vitamin intake and sedation for which paraldehyde is the safest drug.

Rest and inactivity, once a cardiac lesion has healed, do not prolong life . . . Too much rest is likely to lead to physical and emotional incapacity. These statements were made in *Circulation*, journal of the American Heart Association, by three leading authorities on the care of cardiacs. They suggest that "we must accept the philosophy that work is a normal part of living and important for the physical and emotional well-being of the individual."

Social influences that may hinder recovery such as an over-protective wife or children, advice from well-meaning but uninformed friends, and too restrictive medical counsel tend to emphasize the gravity of the ailment and add to the disability.

The return of heart patients to work is also important to the national well-being. Unless these people can support themselves they will be dependent on their families and governmental aid and will pose a staggering economic burden.

— American Heart Association, *Newsletter*

Geriatric Nursing in the Home

LORRAINE F. MILLER

There is an increasing demand for visiting nurse service to the elderly in their own homes. With the help and support of nurses and the patients' relatives old folk can live out their last years in happiness in the security of family life.

TWO THOUSAND YEARS ago the average life expectancy was 20 years. In 1900 it was 49 years — today it is 70 years. An increasingly large number of Canadians are living longer than 70 years as the following comparisons shows.

Percentage of Total Population for Different Ages.

	1956		1958 (estimate — June 1)	
	65+	70+	65+	70+
Nfld.	6	3.8	6.5	3.6
P.E.I.	10.4	7	10.7	7.3
N.S.	8.5	5.6	8.8	5.6
N.B.	7.8	5	8	5.3
Que.	5.7	3.4	5.6	3.5
Ont.	8.5	5.3	8.1	5.1
Man.	9	5.6	9	5.8
Sask.	8.9	5.5	8.9	5.8
Alta.	7.3	4.4	7.1	4.5
B.C.	10.9	6.9	10.2	6.8
Y.T.	4	2.5	3.1	1.5
NW.T.	2	1.5	2.5	1.5
Canada	7.7	4.2	7.5	4.8

Canada Year Book, 1959

In the two-year interval the over 70 population increased in six provinces, with a national average of 0.6 per cent. In 1956 the population of Canada totalled 16,080,791 of which 1,243,938 were 65 and over and 779,825, 70 years and over. In the next two years the population increased by 967,207 — the number over 65 was larger by 41,462 and the number over 70 by 42,475.

Meeting the problems of an aging population is a major task. What can be done to make "the last of life the best?" Too many of our senior citizens are not enjoying these latter years. They are often the tragic products of a society that has lengthened their life span without planning and providing for the consequences.

In a study of 95 individuals (36 hemiplegics) who were being given custodial care as "chronics," only seven were considered to be actually in need of continued institutionalization. Many studies have been made to determine the advantages of home care for the older patient. It is estimated that 92 per cent of patients with hemiplegia can be taught selfcare in six to eight weeks. Many of our so-called chronics are not so "chronic" when they are encouraged to function actively in a family setting.

There are difficulties to overcome in any plan of home care and there *must* be a plan. Personality patterns of both patient and family are affected by long-term illness. In wholesome, happy, well-adjusted families the adaptation and adjustment can usually be made

Miss Miller is director of the Saskatoon Branch of the Victorian Order of Nurses. This material was presented at a Saskatoon Chapter, S.R.N.A., refresher course.

easily in an atmosphere of love and cooperation.

Some of the Problems

Elderly folk, like younger ones, vary greatly. Many at an advanced chronological age are mentally clear and alert, enjoying life. Others who are much younger may require full care. In between is a large group who need some assistance and supervision.

The elderly person for whom a program of care is being developed should be asked to take part in the planning. Parents and grandparents who have accepted responsibility for years and managed adequately should not be suddenly asked to accept changes and plans that others have made for them. They appreciate consideration and, whenever feasible, their advice and reaction toward impending changes should be considered and accepted.

Loneliness is a great problem for the elderly. Their contemporaries may have died, moved away or become unable to get about. The loss of husband or wife leaves the partner lonely and often without an incentive to go on living. Families may contribute to loneliness by moving the elderly person to be near them, but away from friends of their own age group. The family have usually adjusted by this time, but the older person has to adjust to extreme changes at a time in his life when it is not easy. Frequently, elderly couples move to a city where they find life easier but more expensive. Their means are usually limited, so they tend to economize on food. Loneliness coupled with such economy can lead to illness.

To those who have always been active, inactivity causes unhappiness. Sudden lack of something to do results in apathetic listlessness. Grandparents can be asked to help with the housework, handiwork, odd jobs. The home offers many opportunities for activity. Families must accept the fact that most elderly people are happier and healthier when they are encouraged to help and have regular tasks to do.

The Patient and the Family

The family may present a greater problem than the patient. One must always be sure that they can fulfil the responsibilities left with them. Plans for care must be made with consideration for the abilities and emotional involvement of the family members. They are on duty 24 hours a day.

The chronically ill patient, especially those with arthritis, are always hopeful of an elusive "cure." It is important for the family to follow the advice of the physician and not be influenced by well-meant advice from friends and neighbors. The family needs to understand that attaining goals of rehabilitation takes time.

Every patient and his family experience emotional reactions. The elderly must adjust to the frustrations of limited activity; the family must adjust to the loss of a guiding influence, or to the care of a bedfast individual or one who is mentally incompetent. To achieve a happy medium of support and encouragement is all important — doing neither *too much* nor *too little.* Both the nurse and the family must recognize that an uncooperative, ill-tempered patient may be expressing his rebellion and insecurity.

Senile patients may be very difficult to care for at home, but they often die very soon after they are removed from the security that the home affords. The family who keeps a senile oldster at home needs a great deal of help and encouragement. Some days will be good, others very bad. It requires infinite patience and love to meet the demands for care under such circumstances.

Frequently, elderly patients have been active church members. Their spiritual needs remain the same. If attendance at church is not possible, they welcome visits from the clergy. The nurse can often help the family to arrange for such visits or for transportation to religious services.

The need for a break in routine for the family is all-important. "Senior sitters" or a temporary admission to a nursing home may be arranged. Both sides benefit from a "vacation" of this kind.

Physical Care

The program of nursing care aims at providing *active* care. The emphasis is on rehabilitation to whatever level is achievable.

In order to prevent deformities, decubitus ulcers, and other complica-

tions a program of physical care is important. Special skin care is essential for those who are confined to bed. Baths should be spaced, according to individual needs, since frequent bathing may cause dry, scaly skin. The back and other pressure areas require stimulation by friction. A cream-type lotion is better than an astringent such as alcohol. The use of foam rubber pads relieves and equalizes pressure. These must be kept clean and dry. Beds need firm mattresses. Fracture boards help to prevent "hollows." Proper positioning may be achieved by the use of pillows, trochanter rolls, etc.

Activity in bed should be started as soon as the physician permits. Self-help measures and active or passive exercises are recommended, progressing in complexity as the patient's condition improves. When skin care is being carried out, the nurse has an opportunity to teach full range of motion exercises. When the patient can sit up, active rather than passive exercise is encouraged. The aim is to secure the earliest possible ambulation.

> Recently, we were asked to visit a patient who had been in hospital for a full year. Quite literally, he was a "board." The doctor's orders specified that he was to be up. Some weeks and much effort, later, he could bend both knees and had considerable arm and hip movement. He was exercising energetically and expected to be walking "come fall." He was then 87 years of age.

Whenever possible tub baths should be given. A patient can go to the bathroom on crutches or in a wheelchair. To get into the tub the person can be seated on a chair beside it then swivelled around and her feet placed in the tub. Finally she is assisted onto the side and lowered gently into the water. Reverse the process to help her come out. A non-skid bath mat is a must. A firm bar, securely screwed to the wall, can be placed conveniently to assist in getting into or out of the tub. Patients can sit on a chair or a stool under the shower as an alternative. Precautions must be taken against the patient turning on the hot water tap too forcefully.

Individual needs and home resources provide the basis for an individual plan of care.

Sleep

A common problem is presented by the patient who sleeps most of the day and keeps his family up all night. Activity during the day and a hot toddy or hot milk at bedtime can work wonders. The family can help if they accept the fact that an occasional late night is good. If grandfather enjoys T.V. and being in the family circle, he will sleep better after an interesting evening. Elderly people often require as little as five or six hours of sleep.

Having a night light in the room, with familiar objects near at hand and visible, often helps to prevent the temporary confusion that elderly people may display at night. Make sure that the patient is comfortable, warm enough and that the bed clothes are not too heavy.

If a patient is sleepless we should be alert to the possibility of congestive heart failure. Breathlessness at night can be very disturbing. Urinary frequency, another cause of restlessness, may be indicative of urinary infection. Family members must be aware of such symptoms and report them promptly to the nurse or doctor.

Diet

Elderly patients require teaching and encouragement regarding adequate nutrition. Those who are active physically manage very well and seem to have few problems.

> There are three wheelchair patients known to our branch who do all their own housework and cooking. Their homes are spotless. The one thing they need is some gadget with which to pick things up — one patient uses a pair of long tongs. Another lady uses her oven for storage of articles that might be hard to reach. She also uses a small, low refrigerator instead of the larger, higher models and her milkman, breadman and postman all come into the house to make their deliveries. The extra time they spend does not seem to be a problem to them.

The elderly patient who is confined to bed presents a different picture. She tends to eat bread and milk or tea and toast, getting very little of the protein that she needs. Ground meat, homemade soup with meat and vegetables, stews, and baby foods may tempt the very poor eaters. Small meals taken

frequently and hot milk at bedtime may also be helpful in ensuring adequate nutrition.

For those who have difficulty eating, a plastic apron with a bib, helps to keep them tidy. A soup plate with deep sides keeps food in one place. The patient's "feelings" should be considered. One with Parkinson's disease or hemiplegia may reject company because he thinks he is objectionable to others.

Many patients "overdose" themselves with laxatives. A commode chair near the bed reduces the accident hazard. A regular time for evacuation can increase regularity and cut down on accidents.

Suggestions for Care

1. In homes with stairs a folding gate at the top is a guard against falls.
2. A railing along the wall of the staircase will help in steadying uncertain feet.
3. Avoid loose mats, rugs and highly polished floors.
4. Canes and crutches should have non-skid tips. Shoes should be well-fitted and have non-skid soles.
5. A rolling-pin and a pulley arrangement are good substitutes for more elaborate forms of exercise equipment.
6. A chair may be used as a walking aid.
7. A good bed and a firm mattress help to maintain good posture.
8. Safe placement of furniture will prevent accidents.

The Hemiplegic Patient

Perhaps the most challenging patient in the senescent group is the hemiplegic. Too often we see sad results when patients who have had a "stroke" are left to "vegetate." Yet it has been found that 92 per cent can be rehabilitated to good levels of self-care and even to earning a livelihood. The ingredients for success are time, patience, the right kind of philosophy, cooperation and encouragement. Once started on the road it is wonderful to observe what these patients can and will accomplish. They must believe in themselves and in their ultimate success.

We have seen "impossible" miracles happen in our modern world and if we practise believing, it is amazing what we can achieve. By looking forward with those who are now aged and helping them, we are helping ourselves to look to the future when we can say with the poet:

Grow old along with me,
The best is yet to be,
The last of life
For which the first was made.

—Robert Browning

IN THE GOOD OLD DAYS

(The Canadian Nurse — July, 1920)

Does our country need all of its population, or can we afford to allow thousands of our best people to die every year for want of care? Or I can bring the question closer to our hearts by asking: Do our individual homes need every member of the family, or can we easily part with one or more of the familiar faces? — Agnes Joynes, R.N.

* * *

The money value of a man includes the cost of his upkeep and education from his birth till he becomes self-supporting. He then becomes an asset instead of a liability.

This demonstrates the economic loss to the community when, through an accident, he is incapacitated and unable to carry on his work. All the cost of bringing him to the learning stage is wasted, and he again becomes a burden on society.

* * *

Conservation of Nursing Resources

In view of the shortage of nurses, it was highly important to use the available ones where they were most needed. At the very beginning of the influenza outbreak, the Central Registry of Graduate Nurses had a long list of unanswered calls. At the same time it was known that many wealthy patients had two or three special nurses, who could get along with only one or none at all. Repeated appeals were made through the press for self-denial in the matter of nursing service in order that really urgent cases might be cared for.

Life in an Old People's Home

MYRTLE BRODSKY

For some time now there has been intelligent searching and honest concern about what happens to people after they retire. This author gives some answers about those who retire into a home for the aged.

FIVE YEARS AGO a new home for the aged was built in our community. Enthusiasm about it was high since it was felt that such a home would fulfil a need hitherto not met by any existing institution.

The ideal location for the home, or so it seemed to those responsible for planning, was just outside the city limits. The residents would be able to enjoy an open view of lovely countryside. The physical structure of the building provided for every comfort. An excellent heating system and air conditioning made for pleasant indoor living in winter's cold or the oppressive summer heat.

Married couples could live in apartments which provided the privacy of their own living room, bedroom and bathroom. At meal time they would meet with other residents in the communal dining room.

For residents who became ill and required bedside nursing care, an infirmary was available. For those who might show extreme mental confusion, facilities for segregation were provided so that other guests would not be upset.

To all outward appearances the home was everything that any community could desire for its elderly citizens. In actual practice how has it measured up? What is the effect of the environment upon the residents?

One of the most obvious effects has been an apparent obsession with health. The attending doctor's frequent visits and the constant presence of a nursing staff unavoidably tends to create an environment that is associated with illness. The result has been a heightened awareness of ills — real or imaginary. This is an unfortunate situation but since nursing care and medical supervision are required by many of the old people, it is a difficult feature to alter.

The doctor's visit is the great event of the day. He is watched for by many eager eyes. His arrival is a break in the monotony of communal living and an opportunity for pouring out their woes. The house doctor becomes accustomed to listening, is familiar with each person and his or her troubles, but a visiting doctor may find himself "taken in" with rather amusing results.

> One young doctor omitted to ask a patient how long she had been a sufferer from her particular symptoms. He ordered a course of treatment that he hoped would be a cure. When he finally discovered that she had had the condition for the past 30 years, with occasional flare-ups, he retreated to the aspirin plus hot water bottle type of therapy, slightly chagrined!

Medications are given out four times a day and the arrival of the medicine wagon in the lounge is an important event. It punctuates the routine of the patients' lives but it also provides an opportunity to procure that little extra attention that the elderly crave. Residents who have been up and about, suddenly find that weakness and exhaustion make it imperative for them to lie down on their beds and have their medications brought to them. Some complain to the doctor that they are receiving no benefit from his prescription, or that the quantity should be increased. But on enquiry, the doctor may discover that the medications have been refused or taken only intermittently. A certain amount of rivalry may develop in this bid for attention. Individuals who are really in very good health may be influenced by the atmosphere to develop a few aches and pains of their own.

Some residents employ themselves fruitfully and faithfully in the kitchen, dining room, sewing room and carpentry shop. Since they represent a minor-

Mrs. Brodsky was a practical nurse supervisor at a home for the elderly in Ontario.

ity of the total number of residents, this is an area in which more remains to be done through a good program of occupational therapy. Theoretically, the residents are expected to keep their rooms clean and tidy. In practice this consists of straightening bed covers and making a few gestures towards dusting since the heavier cleaning is done by a regular cleaning staff.

We have also noted that a large majority of residents seem unduly concerned with the amount of sleep that they obtain. They complain that they can not sleep at night forgetting that they have spent the greater part of the day dozing, rousing only for meals. The elderly may require, as a maximum, only five to six hours of sleep. This tendency to spend too much time in sleep in all probability might be offset by an organized program of activity and recreation. The residents themselves should be responsible to as great a degree as possible for planning and carrying out such a program. Excessive sleeping might easily be a symptom of boredom and is not necessarily confined to the elderly.

Other advantages of increased activity would be greater enjoyment of their meals, and somewhat less tendency towards overweight. The meals provided are abundant, the food good.

After such a careful selection of location, it was a surprise and a disappointment to find that from the residents' point of view the locale of the home was anything but ideal! Although a grand vista of fields and woods can be seen from the windows, remarks such as "That dreadful bush! Why don't they clear it away?" were frequently heard. They missed the bustle of city life. A city-bound bus calls at the door twice daily but there is a definite need for a community service project whereby the old people could be assured of frequent outings to nearby shopping areas, theatres or other points of interest. It would do much to relieve their sense of isolation and make them more content.

Those who work with the elderly should be prepared to accept the fact that age does not change character or temperament. The person who has been exacting and selfish throughout her earlier life will show these same qualities in her declining years. So will the considerate, generous man or woman. It will help in coping with the individual resident, if as many facts as possible about him or her can be gathered from the family. Considerable tact and patience will be absolute necessities in preserving as harmonious an atmosphere as possible in an environment that features so many differing personalities and fixed patterns of thinking and doing. The latter point is an important one to remember — old age does not have the flexibility of youth. Emotional and physical adjustment is made with more difficulty.

We encountered another factor for which we were perhaps less prepared — a status factor. Some of the residents had only their old age pensions. The financial setup of the home is such that, except for a set amount of pocket money given to the pensioner out of each cheque, the major portion is retained to pay for his board, room and care. This represents a very minimal amount per week. Other more affluent guests were able to pay the full amount set by the administration. These people tended to consider themselves a small aristocracy, and their rather superior attitude was a source of friction. Again, such a situation requires careful handling so that the sensitive old people, who must get along on smaller incomes, retain their personal dignity and self-respect. The same consideration must be shown in helping the old age pensioners to accept the fact that their cheques are no longer under their control. It does reduce their sense of being independent and this may come out in their complaints that they are paying for more than they receive.

The idea that husband and wife should not be parted in the sunset of their lives is an appealing one, that the provision of apartments acknowledges. On occasion, two elderly residents will marry in the home. While we might like to think that these are instances of true, if late-blooming romances, we must be realistic enough to admit that sometimes the attraction of the apartment plays a part. Human nature being what it is, some of the unmarried residents consider the comfort represented by the extra space an undue reward for spouse survival or acquisition!

An elderly person who is mildly

confused can usually manage fairly well under familiar conditions which make no perceptible break in her life-long pattern of living. She can take care of her own personal needs — use the toilet, wash her hands, don an apron and sit down to a meal — automatically and without fuss. Familiar faces greet her. True, she is uncertain if the man opposite her at dinner is her son, grandson or late husband but his presence and smile reassure her that everything is as it should be.

If this person is uprooted and placed with other confused people, in a matter of months she will deteriorate. A plump, smiling prosperous-looking lady becomes a sunken-cheeked harried-looking creature who appears ten years older; or a benevolent, cheerful chatty old gentleman, soon develops into a silent wraith, immobile and gazing into space. As time goes on these patients becomes too inert to come to meals or use the toilet without constant and often fruitless urging. This is an effective argument against segregation of the confused person unless it is absolutely necessary.

The provision of an infirmary in the home is primarily for the purpose of providing incidental care for residents who otherwise enjoy reasonably stable health. As might be anticipated, a certain number of the old folk tend to become "chronic" infirmary patients. They appear with great regularity to recite their symptoms but again, one might suspect that their greatest need is not a pharmaceutical remedy but an increased dose of T.L.C.

No home is better than its nursing staff. However efficient the supervisor of nursing may be she is very dependent on a minimum staff of registered nurses and a number of practical nurses whom she endeavors to direct in the best interest of the residents. Unfortunately, registered nurses who are physically active and experienced are not usually attracted to this type of employment. A home for the aged may have to depend on nurses who find the rush of the general hospital beyond their capacities or on married nurses with families to care for. A few are attracted by the greater freedom in the working conditions, not possible in highly regulated hospital life.

The right type of applicant for the practical nurse staff is even more difficult to find. Strict hospital discipline is not possible in a home. The few registered nurses who are responsible for the performance of others may be fearful of being called to task if their disciplinary action causes a practical nurse to resign. Labor is difficult to replace and administration does not relish continual turnover of staff.

Conclusion

In our parents' or our grandparents' day, homes for old people were unknown. The younger members of the family and the elderly father or mother lived together in a house built with an eye to future needs in accommodation. The present need for homes for the elderly represents a trend in social conditions. Small houses and apartments cannot usually accommodate an extra member of the family. Even if there is a room, the elderly person may not be happy living in crowded quarters with a young couple and their children. If an aged person is well and wishes to live alone, even in one room, the family may feel guilty and decide that their relative would be better in a home with others of her own age. This attitude frequently implies a lack of understanding of the needs of the aged to retain independence and dignity. An awareness of the needs of the elderly is the family's most important responsibility.

The story of Mr. Smith is typical:

He was a violent-tempered, pinched-face little man who spent most of his time in the home lying on his bed. He often threatened staff members with his crutch when they came near him. A relative removed him from the home and one day he was seen on a city bus by a member of the nursing staff. He chatted happily with her and pointed out his solitary housekeeping room as the bus drew up to the curb.

As he was about to descend from the bus the driver told him that he must not try to ride on the bus again without a ticket. Mr. Smith became enraged, as he had often done at the home, but he did not attempt to use his crutch as a weapon. He stomped out of the bus, allowed the driver to hand him down his well-filled shopping bag, and then held up the bus while he walked majestically in front

of it toward his lodging across the road.

The world is usually kind in making allowances for the handicapped and both benefit immeasurably. The violent temper could be controlled and the development of a feeling of self-sufficiency made it possible to replace perpetual lying in bed with shopping trips and some measure of normal activity.

Hospitals, for those who are not acutely ill but need some nursing care, are necessary and should be available to all who need them. The decision that an elderly person needs to be institutionalized should be made by a board of experienced medical men. An "incurable" condition does not necessarily imply an inability to play a comparatively normal role in community life, even if the role is an increasingly passive one.

Many of us will live to become elderly — not necessarily confused or "incurable." Let us not create ever-expanding little communities of senior citizens. If they are allowed to keep their known patterns of living at a time when change is so very difficult, they would not become a burden to themselves or to others.

Nursing Home Care in Geriatrics

ISOBEL V. SCRIVER

Geriatric nursing is not for every nurse. Would you like to try? Are you suitable?

GERIATRICS HAS BEEN defined as "the medical treatment of the aged" and "the branch of medicine which relates to diseases of old age." The Geriatric Centre in Saskatoon does exactly that — gives medical treatment to the aged and their diseases. The centre is rehabilitative in that patients are encouraged toward self help.

In recent years we have been able to look at the brighter side of old age and no longer think that reaching the "eventide of life" is so frightening. The rocking chair, as a symbol, has been discarded; yet in some instances a too glowing picture has been painted. While these years are not necessarily ones of physical and mental deterioration in which little can be done, neither are they an earthly paradise or a golden age when nothing *needs* to be done. To work effectively with older people, our attitude must be realistic.

An understanding of the emotional problems of older people requires consideration of the stresses of later life and their effect on previously existing personality structures. The most common stresses are physical and mental limitations or disabilities. These have been brought on or aggravated by retirement, diseases which cause helplessness, loss of a mate, relative or close friend, rejection by their own children. Some are subjected to few hardships, others to heavy ones, but the effect on the individual varies. The type and degree of stress is not necessarily proportional to the effect. The individual response depends on previous patterns of response to stress.

The Geriatric Nurse

The nurse in geriatrics does not need personality characteristics or abilities that are different to those of nurses in other fields. It is the degree to which she must use certain abilities that is increased.

She needs to have:

1. *Sympathy, kindliness and thoughtfulness* without pity.
2. *A sense of humor.*
3. *Patience and tact,* for the aged become garrulous and somewhat unreasonable at times.
4. *Flexibility,* since most older people are fixed in their ways. If, in our attempt to cure, we try to change them, we achieve little more than making them unhappy. Frequently unhappiness causes confusion.

Miss Scriver is director of nursing services at the Geriatric Centre, Saskatoon.

5. *Teaching ability.*

6. *Physical energy* and the ability to use it wisely.

7. *Well-developed powers of observation* so that she can recognize the emotional needs and signs of worry in the aged patient. Worry and fear may be alleviated by explanation or by allowing the patient to talk and express his fears. If a nurse becomes well-acquainted with the patient's history and family background she will be able to help him to adjust to a new way of life in the nursing home.

8. *Adaptability* to meet the particular needs of each guest. Not all old persons are deaf — the belief that they are is deplorable. Many have hearing limitations which are overcome if one speaks slowly and clearly. The nurse should face the patient and stand in a good light in case he is dependent on lip reading.

9. *Judgment* in answering questions, knowing when to refer queries to the doctor and answering those within her field in language that is readily understood. An old person who is ill and clutching at the hope of recovery and self-sufficiency may easily misinterpret statements made by the doctor or nurse.

Forgetfulness, so common in senility, is the senile mind's way of protecting itself from painful memories. We have been amazed by the elderly gentleman who could not find his way home from a neighborhood grocery store but could repeat accurately the details of a football game that took place 40 years ago. The explanation is simple. The man enjoyed remembering the happy times but the same man, who retired as a plant foreman to become an errand boy for his wife, sub-consciously finds it so painful to return home that he cannot remember his way.

The nurse who takes the trouble to get to know her aged patients may frequently benefit from a philosophy of life which only the passing of years can bestow. However, it must not be assumed, because a person has lived many years, that he is necessarily mature emotionally.

Maturity is not a matter of years. Each person will respond on the basis of his or her personality, and this individuality is of primary importance in planning nursing care.

The personality reactions of the aged are not only individual but are based on the mode of another era. An elderly person may be liberal and tolerant of his own era but he may also have reactions that, through time, have become a set pattern. These cannot be changed without causing considerable stress.

If grandfather has been in the habit of sleeping in his underwear all his life, he is certainly not going to wear pajamas at 80 years of age when he is admitted to a nursing home. Nurses in a home for the aged have to learn that such habits are of minor importance to nursing care, but are of major importance to the patient if he is expected to give them up. We have to adjust ourselves to our patients, not they to us.

The aged need attention, affection and to be heard. They are individuals, the same as we are. It is like looking into a mirror and seeing ourselves in years to come. If we educate ourselves to meet this phase of life, then it should not be too hard. We cannot escape. We must all grow old. Let us prepare ourselves to do it graciously.

SLOW DOWN AND LIVE!

1. *Keep your car in top condition.* Steering gear, brakes and lights are especially important. Watch your tire pressure. Improperly inflated tires + hot summer roads = blowout disaster.

2. *Keep your eyes on cars behind and in front of you.* Anticipate what the other driver may do and keep your distance — a car's length for every 10 miles of speed.

3. *Stay alert.* On long drives stop q.2. h. for coffee — iced is as effective as hot. Walk around and relax for a few minutes.

4. *Share the wheel.* Don't fight fatigue. Pull over to the side of the road and take a rest.

5. *Know and obey traffic regulations.* Speed, too fast for conditions, is the most common cause of highway fatalities.

— Canadian Highway Safety Council

UMBILICAL HERNIA

ROSEMARIE PERKA

A patient's attitude toward illness, his willingness to cooperate and the extent to which he trusts the efforts of those who care for him can be major factors in recovery.

Sociological History

Mr. Dion was the eldest son of a French-Canadian family. At 22 years of age, he married a girl almost his own age, and from this union were born nine children, three sons and six daughters.

He appeared to have devoted his entire life to his wife, children, and grandchildren. His ability to give to others instead of to receive was evident in the way he kept up the morale of his roommate and brought cheer to the staff or anyone who visited him.

Mr. Dion lived on a farm near his birthplace for almost 50 years, after which he moved with his wife and family, to a farm in one of the Western provinces. Two years ago he gave his farm to his youngest son and his family, and bought a house in a nearby town where his wife and he are living presently. He was, at first, quite reluctant to leave the farm but, as he said, "I was getting too old and stiff to be a good farmer."

His attitude towards his retirement was one of complete acceptance. He began keeping a large garden of flowers and vegetables, his favorite crop being his bountiful potato patch. By these activities, he has been able to compensate for his retirement and still remain happy and satisfied. He has many friends in his neighborhood whom he visits occasionnally with his wife.

Mr. Dion receives the old age pension and his hospital stay was entirely free from financial worry. Probably this was one reason why he appeared so cheerful. Since a cause for worry had been eliminated, his recovery was hastened.

Reaction to Illness

Since Mr. Dion was admitted through the emergency department and had to have his operation almost immediately, his family were very concerned. However, as soon as the urgency of the hospitalization and surgery had passed, the strain and tension diminished rapidly. Instead of sending flowers or candy, they arranged to take turns visiting him so that he was never alone during visiting hours. Doing small things, such as giving him a haircut or shave, and bringing him little bits of his favorite foods replaced the more extravagant outward show of affection. His family's constant and loving thoughtfulness certainly affected Mr. Dion's recovery. He was always jovial and had a smile for everyone.

His personal reaction to his surgery and hospitalization was one of willing surrender to and total cooperation with his doctor and members of the hospital staff. His faith in his doctor had no limit, and he was eager to help in any way he could. His attitude to his illness had a definite influence on his quick recovery since he did what was asked and expected of him and refused no phase of his medical or nursing care.

ROSEMARIE PERKA

Miss Perka, a student at Edmonton General Hospital, received a $25 prize for her study in this year's Macmillan Award competition.

Mr. Dion did not worry about how his surgery would affect his future. Rather, he began slowly to mold his pastimes into a pattern that would be of most benefit to him. He planned to have a much smaller garden and to eliminate heavy work from his daily routine. In addition, he intended to try to relax for a short while after his meals, and especially during the afternoon. He fully understood how his operation would affect his activities.

Physical History

Mr. Dion's first admission to a hospital was nine years ago when he was admitted with a diagnosis of benign prostatic hyperplasia. A suprapubic prostatectomy was performed successfully, and he recovered quickly with no after-effects.

Six years ago he developed an attack of influenza and suffered from severe coughing spells. During one of these spells he felt a sharp pain in his abdomen and noticed a bulge just below his umbilicus. This bulge was not troublesome, so Mr. Dion did not seek medical attention. A few days prior to this admission, the hernia became tender and appeared slightly edematous. Mr. Dion began to lose his appetite rapidly. The day of his admission he had severe abdominal pain with nausea.

An umbilical hernia is a protusion of a loop of intestine through the umbilical ring. It is caused either by the failure of the umbilicus to close at birth, or by a congenital defect in the umbilical scar. The weakened muscle wall may then open due to increased intra-abdominal pressure such as pregnancy, intestinal obstruction, or as in this case, a severe cough. Umbilical hernias are common in obese and elderly people.

Because Mr. Dion was admitted through the Emergency Ward, there was little time for routine tests. A specimen of urine was sent for a complete urinalysis. The results revealed a slightly abnormal urine content.

The color was clear yellow which was normal.

The specific gravity was 1.012 and within the normal range of 1.010 - 1.030.

The pH or acid-base reaction was 5.3, the normal being 5-7 and slightly acid. It was negative for the presence of sugar and red blood cells.

Protein was present in small amounts indicating, in this case, a form of either glomerulonephritis (primary involvement of glomeruli) or nephrosis (primary involvement of tubules.) There were occasional casts in his urine — an abnormal finding that is due to some form of kidney injury. Casts are tiny masses of material that have hardened in the tubular lumens and therefore assume the shape of the lumens.

The only other abnormal constituent present was occasional pus cells, indicative of infection in either the bladder or renal pelvis.

Medications

Preoperatively, Mr. Dion received 500 mgm. achromycin in each 1000 cc. of intravenous solution. Achromycin is a highly efficient antibiotic, effective against Gram-positive and Gram-negative bacteria, as well as many other types of microorganisms. It is preferable to most other antibiotics because it produces fewer gastrointestinal disturbances — a very important factor in Mr. Dion's case as there was less likelihood of strain on the suture line. Achromycin can be given orally or intramuscularly in doses of 50 to 250 mgm. three or four times a day. Its only toxic symptom is diarrhea. This is usually too mild to warrant cessation of the administration of this antibiotic. Achromycin was given to help prevent wound infection and to clear up the urinary tract infection that may have been responsible for the presence of pus cells in the patient's urine.

Preoperative sedation consisted of Demerol 75 mgm. and atropine gr. 1/100, given one hour in advance of operation. Demerol is less likely to cause gastrointestinal distress such as nausea, vomiting, and respiratory depression. It is used to relieve distress associated with spasms of smooth muscle. Atropine relaxes smooth muscle tissue.

As a general anesthetic was being used, an intravenous solution of 10 per cent Travert in water with achromycin 500 mgm. was started in Mr. Dion's right arm. This was established because, until normal peristalsis returns, both food and fluids are restricted orally postoperatively.

Morphine sulfate gr. ¼ was ordered q.4h., p.r.n. for postoperative discomfort. Morphine sulfate is one of the most reliable drugs for relief of severe pain, and in this instance it was used espe-

cially to decrease intestinal peristalsis and allow healing to take place.

Treatments

Abdominal surgery requires the use of a continuous Wangensteen suction since it is desirable to keep the gastrointestinal tract empty and at rest until normal peristalsis resumes. It is an effective method of removing the secretions, air or gas which often accumulate in the gastrointestinal tract following abdominal surgery. Suction, then, prevents distention.

Before Mr. Dion was taken to the operating room a Levine tube was inserted into his stomach. He had continuous suction for three days during which time it drained a small amount of brownish yellow fluid.

While the Wangensteen suction was in operation a total of 6500 cc. of intravenous fluid was given. Immediately following surgery, he received 4000 cc. of 10 per cent Travert in water with 500 mgm. achromycin in each 1000 cc. of solution. The Travert in water helped maintain a high nutritional standard. In addition, to the glucose solutions, Mr. Dion was given 2000 cc. electrolyte No. 2 and 500 cc. of normal saline to ensure adequate electrolyte balance.

He also received an oil enema. This was to soften feces and lubricate the anal canal. Because Mr. Dion had not received a preoperative enema, he became constipated postoperatively and was unable to expel the oil until the next day. The enema was effectual. A considerable amount of flatus and a large amount of soft brown stool was expelled with the oil. This indicated that peristalsis had been regained so Mr. Dion was able to take food and fluids orally.

Diet

On the third postoperative day the Levine tube was removed and the patient received fluids orally. At first he was given one ounce of water q. ½ h. On the fourth day he received clear fluids such as apple juice, tea and jello. The fifth day, he began a soft diet which consisted of eggs, white toast, broth, ice-cream, milk, tea, cream of wheat and jello. Two days prior to his discharge from the hospital, he was placed on a light diet. Mr. Dion accepted his diet well. He was at no time nauseated after eating. At the time of his discharge he was on a regular diet and was able to eat all foods, which pleased him greatly.

Nursing Care

The *preoperative care* was carried out in the emergency room. A major and minor skin preparation was done by an orderly shortly before surgery. Green soap was used to cleanse the skin before shaving, and ether and alcohol were used to paint the area afterwards.

Fasting before surgery to prevent nausea and vomiting from the anesthetic is customary. However, he stated that he had only eaten a small dinner that day, and had had an emesis following it.

Mr. Dion voided immediately before operation. This eliminates displacement of the abdominal organs due to a distended bladder, and prevents accidental injury to or rupture of the bladder during surgery.

Surgery: After anesthesia was established, the surgeon made a transverse incision just below the umbilicus to expose the herniation. The hernial sac was removed, the bowel replaced in the abdomen and the peritoneum closed. To prevent recurrence of the hernia and to facilitate closure of the defect, a hernioplasty was done by suturing stainless steel mesh to the fascia to strengthen the muscle wall. The skin layers were then closed with interrupted mattress sutures.

Postoperative care: Mr. Dion was brought to the ward immediately following his operation. As soon as he was settled comfortably in his bed, his blood pressure, pulse and respirations were taken at 15-minute intervals until they remained relatively stable.

He was given morphine sulfate gr. ¼ to minimize pain and discomfort and to allow him to rest quietly throughout the night. He received this narcotic the following afternoon for pain in the operative area, and again at bedtime for three consecutive evenings to ensure a good night's rest and reduce peristalsis.

Early the first morning Mr. Dion began arm and legs exercises as well as deep breathing to prevent such postoperative complications as hypostatic

pneumonia, thrombophlebitis, and intestinal obstruction. Since he had not been taught these exercises before his surgery, it was necessary to teach him postoperatively. He was very cooperative and it did not take long before he was doing his exercises every hour without having to be reminded of them. After turning from side to side a few times, Mr. Dion realized how much more comfortable this made him feel. As he was obese, he perspired easily and his skin soon became tender. This was relieved by frequent back rubs.

He developed a cough, and to prevent any strain on his suture line, he was taught to splint himself by firmly pressing against his incision with his hands whenever necessary. He was able to cough more deeply, which was a good preventive measure against pneumonia. He was not afraid to cough or to turn in bed when thus splinted.

Mr. Dion had no trouble voiding after his operation. Two days after surgery he sat in a chair for the first time postoperatively. He was not dizzy or overly tired after this experience. This pleased him immensely and encouraged him to either sit on the side of his bed by himself or to get up into a chair if someone was present to help if needed.

Four days postoperatively he was able to take short walks about the ward without assistance of any kind. This greatly improved his morale and was an important factor in hastening his recovery. On his eighth day, one half of the sutures were removed. He was discharged the next day with an order to visit his doctor at his office the following week for the removal of the remaining sutures.

Mr. Dion left the hospital with the understanding that he would have to be careful for at least a few months after his discharge. He would not be able to move or lift heavy objects; do any tiring, strenuous labor. These limitations of activity were easily accepted. He was rapidly regaining his former strength and was confident that it would be only a short while before he would be "my old self again."

Spinal Injury and Paraplegia

EMIKO ADACHI

We may complain that our feet hurt or that our legs ache at the end of a long, busy day. But what would it be like to have to face the knowledge that we would never walk normally again?

MR. MARTIN WAS ADMITTED with a spinal injury and paraplegia. X-rays showed a fractured dislocation of the vertebral column in the dorsolumbar area. At operation the surgeon found a dislocation and rotation to the right of the facets joining the 12th thoracic and first lumbar vertebrae. A ruptured intervertebral disc was also discovered. The *nucleus polposus* or central core of the disc had herniated through the posterior ligament which supports it, into the spinal cord. This herniation caused pressure on the lumbar and sacral nerve roots and was partly responsible for the pain that Mr. Martin experienced.

Fractures of the spine may result from a disease process, or some type of injury. Accidental fractures are caused by falling while in a sitting or stooped position; by a direct blow to the spine; by falling in a jack-knife position in which case the shoulders and hips take the force of the injury.

The vertebral column protects the spinal cord and keeps the body erect. Therefore, a spinal fracture will affect the cord and its nerves. A severe dislocation of vertebrae may sever the cord causing immediate and complete paralysis below the fracture. A minor displacement may cause com-

Miss Adachi who is a student at the University of Alberta Hospital, Edmonton, was awarded $25 for this study in the recent Macmillan Award competition.

pression and pressure on the cord with a delayed response of pain and paralysis. Compression, if slight, may not cause any neurological disturbances. Sometimes the main body of the vertebra remains intact and only the lateral or spinous processes are broken. The degree and the direction of damage produce a variation in subjective symptoms. Mr. Martin had extensive cord injury. There was compression and pressure plus a great deal of soft tissue damage. Paralysis below the fracture site was evident.

Social History

The patient was 24 years old and worked as a laborer in the city. He had one sister who was a year his senior. He said very little about his family life and apparently did not get along well with his father. He felt that he was the "black sheep" of the family. He had a great deal of love and respect for his mother. He was a very congenial young man, pleasant to work with but very uncommunicative about his accident, his past experiences or his friends.

This misfortune set him back socially, physically and financially. It upset him mentally as well. He had hospitalization coverage but no medical insurance, and his accident did not qualify him for Workmen's Compensation since he was not injured on the job. He was a long-term patient and his adjustment depended upon his courage and his will power.

Medical History

Mr. Martin had always been very healthy. There was no family history of inherited disabilities or illnesses. His only previous hospitalization was for a tonsillectomy when he was a child.

His recent hospitalization was the direct result of a rather mysterious accident. He may have been the victim of a hit-and-run accident or of foul play. He did not remember, nor did he seem to wish to remember, any part of the incident. There were no witnesses. He awoke from an unconscious state to find himself lying in a ditch. It was foggy and there was no traffic on the highway. He crawled about 100 feet since he could not get up on his feet. However, he was unable to crawl up the incline of the ditch to the highway and remained by the roadside for four hours before two hunters found him. He was taken to a local hospital for preliminary treatment, and then removed to ours.

On admission his primary distress was his excruciating back pain and inability to move his legs. His blood pressure was 130/86, pulse 76. He was in psychological shock. He stated later that he could not recall anything from the time he received an analgesic in the local hospital until he found himself in the recovery room here.

He was examined, x-rayed and immediately prepared for an emergency operation. His hemoglobin was high — 96 per cent or 14 gm. His urinalysis was essentially normal. He had slight dyspnea but no cough and his lungs and chest were clear. His abdomen was soft and tender; bowel sounds were present. He did not seem to have any internal abdominal or thoracic injury. There were no signs of cardiovascular disease. All cranial nerves were intact. There was no history of headache, dizziness, visual or aural disturbances. Mr. Martin had good arm coordination, power, sensation and reflexes but he had complete leg paralysis and weak muscle tone. He had no sensation from waist to toes. Reflexes were absent. His back pain was localized in the midline of the dorsolumbar region. There was a slight blood discharge from his nose.

Following operation, further laboratory tests were taken for postoperative comparison. The urinalysis remained essentially unchanged, with some red blood cells present in the sediment. The white blood count was slightly above normal at 11,300 but not a sufficient rise to cause alarm. The red blood count and platelet count appeared normal. His hemoglobin was slightly reduced to 80 per cent. The sedimentation rate was increased to five times above normal at 50 mm. per hour. An increase is indicative of infection or an inflammatory condition. A portable x-ray of the thoracic and lumbar regions showed that the dislocation of the spine had been reduced.

Later x-rays indicated a slight compressed fracture of the first lumbar vertebra but no evidence of dislocation. The alignment appeared within normal limits. The disc space between the injured vertebrae was still narrowed.

Treatment and Nursing Care

Preoperative care: Great care must be taken in the first aid treatment of spinal injuries at the scene of the accident. Caution should be used in transporting the patient in order not to flex his back. Improper handling and positioning aggravate the injury.

At the local hospital Mr. Martin was given 100 mgm. of Demerol to relieve his severe back pain. After appraisal of his general condition he was transported by ambulance to this hospital with a referral to a neurosurgeon. Upon admission he was examined, prepared for surgery, measured for a Stryker frame and a Levine tube and Foley catheter were inserted.

If Mr. Martin had not been an emergency admission the preoperative care would have been more "patient-centered" rather than "surgery-centered" as in this case. There would have been more time to prepare him physically and mentally for an operation. The routine care of an enema, tub or bed bath, fasting after midnight, would have been observed. He would have been given a more adequate explanation of the Stryker frame and its advantages, and helped to adjust mentally as well as physically to a new and different routine. When a patient acquires a basic knowledge of his condition and can accept his circumstances, he is better equipped to face surgery and postoperative treatment. A well prepared preoperative patient makes a more cooperative postoperative patient. The postoperative routine and the patient's responsibilities, such as deep breathing, coughing, should be discussed. The significance of drainage tubes requires explanation. The patient needs to become acquainted with the ward routine as well. In this instance only essential data were compiled. Mr. Martin was sent to the operating room without preoperative sedation since he had received Demerol several hours earlier.

He was anesthetized with sodium pentothal by intravenous injection and then placed in prone position. Anesthesia was maintained with pentothal, nitrous oxide, oxygen and Demerol. Demerol in divided doses up to 65 mgm. was given throughout the operation to raise the pain threshold, to promote spasmolytic effect and thereby reduce nerve and muscle irritability in order to lessen the anesthetic required. Hyoscine gr. 1/150 was administered intravenously to reduce gastric and salivary secretions and the tendency to vomit under anesthesia. Adrenalin was given to decrease the amount of peripheral bleeding by constricting the peripheral blood vessels. Intravenous therapy of 5 per cent glucose in 0.2 per cent sodium chloride solution was started to keep a vein open for the administration of drugs and in the event that a transfusion was necessary. Dextran, 500 cc., was used to expand plasma volume, to maintain blood pressure and to lessen the possibility of shock. To promote muscle relaxation Succinyl 0.1 per cent was given and maintained with an Anectine drip 0.1 per cent.

The neurosurgeon performed a laminectomy to reduce the dislocation between the 12th thoracic and first lumbar vertebrae. This relieved some of the pressure on the spinal cord. The intervertebral disc was also removed with debridement of the surrounding soft tissue and insertion of a nylon graft. The spinal cord was stabilized by wiring the spinous processes together.

Postoperative care: Mr. Martin was placed on the Stryker frame and remained in the recovery room until he was conscious and responding well. His Levine tube was clamped when he began taking sips of water without any signs of nausea. Vital signs were recorded every hour to make certain that he did not go into surgical shock or begin to hemorrhage. They remained fairly stable. The intravenous injection was discontinued.

Early in the evening following surgery Mr. Martin felt nauseated and vomited approximately 150 cc. of mucus and blood-tinged fluid. His Levine tube was reconnected until his nausea subsided. During the night he had no further nausea. His Levine tube was clamped without ill effect and he drank moderate amounts of fluid. His catheter drained well and upon irrigation the return flow was clear. A routine postoperative urine specimen was sent to the laboratory in the morning to determine if there was any liver damage due to anesthesia.

Throughout the evening and night Mr. Martin's blood pressure was sta-

ble, his pulse strong and regular. His pupils were equal and reacted normally. He was immediately started on a routine of regular turning every two hours. Frequent change of position and good skin care are very important to the paraplegic patient in the prevention of bedsores and other complications. Daily nursing care included a complete bath each morning and observation of the condition of the skin and his dressing. The turning routine was arranged so that he was in a prone position for meals and on his back during the morning for elimination purposes and, later, for visiting hours.

The Stryker frame has definite advantages. It facilitates nursing care in that the patient can be turned frequently with a minimum of discomfort to himself and of time and energy for the nursing staff. Body alignment, which is of utmost importance in this type of injury, is easy to maintain. Drop foot may be prevented by means of the foot-piece. The risk of complications such as pneumonia, kidney stones and circulatory disturbances is minimized.

The few disadvantages are that the frame is fairly narrow and not so comfortable, at first, as a bed. The patient may have difficulty in adjusting if he has been in the habit of sleeping on his side. Mr. Martin encountered this problem.

Care must be taken that the patient is held tightly between the frames during turning with his arms folded around one frame. He should be turned smoothly and fairly quickly by two nurses and the stabilizers replaced immediately.

During morning care, on the first postoperative day, there was no visible oozing on Mr. Martin's back dressing. A moderate amount was noticed on his nasal dressing. His hemoglobin was checked and found to be 98 per cent. Considering the psychological shock and the strain occasioned by a lengthy operation, Mr. Martin progressed very well postoperatively. The first three or four days called for courage and determination. Supportive nursing care, physical, mental, and emotional was essential.

When Mr. Martin's vital signs remained fairly constant, they were checked and recorded less frequently. At times his respirations were irregular and he appeared short of breath. During the first evening he perspired profusely, probably as the result of tension and pain. Although his temperature remained normal he was placed on antibiotic therapy. Oral penicillin tablets were ordered t.i.d.

He suffered continual severe pain. Demerol 100 mgm., was given intramuscularly q.4h. to relieve it. Sleep is not usually induced with Demerol so for sedation Mr. Martin received seconal gr. 1½, a short-acting barbiturate.

On the second postoperative day the Demerol was discontinued to prevent tolerance or habituation. Aspirin and phenacetin compound with codeine gr. ½ tablets ii, q.4h. p.r.n. were substituted. Occasionally, in the days that followed, Mr. Martin's back pain became so excruciating that Demerol was ordered. Phenobarbital gr. ½ t.i.d. was given for postoperative tension and restlessness.

Three days postoperatively, Mr. Martin had an incontinent bowel movement. Incontinency is one manifestation of spinal injury and results from impairment or loss of control of the anal sphincter. Other complications that appeared later were constipation and fecal impaction due to sluggishness of the gastrointestinal tract. He was given Dulcolax tablets ii daily. This preparation creates or stimulates normal peristalsis. A soapsuds enema was ordered every second day to cleanse the bowel and reduce complications.

As Mr. Martin's pain lessened in severity, he became more cheerful. Sparine 25 mgm. t.i.d., was prescribed to relieve apprehension, anxiety and agitation. Once past the acute postoperative phase, he began to do some of his own morning care, to read, and to take a greater interest in his surroundings. The patient's morale falls to its lowest ebb when he has nothing to do and has time to think about himself. He must be helped to acquire a positive approach to health and to his future. His nurses can give him hope, reassurance and encouragement.

When Mr. Martin's sutures were removed, the incision appeared clean and well-healed. A dry dressing was applied. About 10 days after his oper-

ation Mr. Martin complained of severe pain in his bladder. It was irrigated and the following morning a urine specimen was sent to the laboratory. The report showed numerous bacterial and pus cells present. This indicated infection of the urinary tract. Catheter drainage was checked carefully and the urinary output was in normal proportion to his daily intake of fluids. Prevention of urinary infection is very essential since it is a major cause of death in paraplegic patients who survive the initial shock and trauma. Usually these patients have a urinary problem due to sensory and motor nerve loss to the muscles and sphincters. The indwelling catheter solves the problem of retention and distention. The patient with an indwelling catheter must be placed on recorded intake and output. Fluids are forced to over 2500 cc. daily, in order to maintain good kidney function.

In caring for the patient with a catheter good aseptic technique is very important. The amount and color of the urine must be checked, the drainage bottle cleansed and rinsed daily and the tubing sterilized regularly and changed as necessary. Washing and general cleanliness of the perineal area is essential.

Mr. Martin had more difficulty with his catheter about two weeks later. It became blocked and his abdomen was very distended. His catheter was changed and this gave him relief and improved drainage. The incident depressed him considerably.

Rehabilitation

Mr. Martin became rather withdrawn after his doctor had told him that his chances for the return of sensation and motor power in his legs were slight. He began receiving physiotherapy daily. His muscles and limbs were put through a normal range of motion. This stimulated circulation, helped in retention of muscle tone, and prevented contractures. Exercises were given to strengthen the muscles of his abdomen, back, shoulders and arms. These muscles are important in instituting special rehabilitative techniques for they act as the "work horses" in helping the paraplegic patient to walk again.

Shortly before he was taken off the Stryker frame Mr. Martin was ordered to go on the standing board in the physiotherapy department. It was explained that this placed his weight on his legs and helped to maintain muscle tone and improve circulation; that it helped to promote normal kidney function by prevention of stasis and the formation of renal calculi. He was strapped to the table and gradually brought to an upright position. This was his first step in special rehabilitation. Rehabilitation is a science of "continual progress" in which a disabled person is taught to "regain his maximum physical, mental, social, vocational and economic usefulness." The person as a whole is considered and treated. The aim is to help the patient help himself. Nursing care and rehabilitation have the same basic foundation but the latter is more specialized and is directed to handicapped people. Mr. Martin's program of rehabilitation, as with any other patient, emphasized the capabilities remaining to him.

Within a few days Mr. Martin began "sitting up" exercises and five days later he was transferred to a bed. This new status was achieved five weeks after his operation. It did not mean, however, that his troubles were over. He was still fighting a bladder infection that plagued him with malaise, fever, chills, weakness and general lethargy. Penicillin therapy was replaced by Gantrisin, a sulfa preparation, 1 gm. q.i.d. This helped to quell the infection. Bladder irrigation, changing the catheter regularly, cleanliness, aseptic technique, and forcing fluids helped as well. The same general nursing care of q.2h. change of position with proper body alignment, bed baths, back and foot care was maintained. A Balkan frame was attached to his bed so that he could raise himself to a sitting position to assist in his morning care, to eat his meals and to strengthen his arm muscles.

In approximately three weeks, through the efforts of the physiotherapists and his nurses on the ward, Mr. Martin was promoted to an even more independent state. He had access to a wheel chair, courtesy of our social welfare worker, and he began to move about the ward, the physiotherapy and occupational therapy departments by

himself. He continued with an extensive program of exercises and started to stand by himself between the parallel bars. He also practised a routine of "daily living exercises" in which he learned to dress himself, to move from his bed to the wheelchair, from the wheelchair to the toilet etc. While this program was initiated in physiotherapy it was performed regularly on the ward and each day he became more independent and self-sufficient.

Mr. Martin appeared to adjust to hospital life and to accept his handicap but he had a mental block toward social or community life. He was afraid to be discharged. He had a big adjustment to make in the field of recreation and future employment. He did not particularly care for reading, listening to the radio, watching television or doing occupational therapy. His interests were in outdoor work, dancing and active sport. He would not be able to return to his former job and he had to consider other types of work. It seemed probable that he would complete his high school education and take further studies in accounting, bookkeeping or vocational training for work that did not require the use of his legs.

Conclusion

Mr. Martin's injury caused permanent damage to his spinal cord and he will continue to be paralyzed from his waist to his toes. In a spinal injury the lower the lesion is, the better the prognosis. If the patient survives the first critical weeks against the problems of trauma, shock, severe urinary infection and bedsores he can expect to live for many years and lead a fairly active life. Rehabilitation is usually slow but the patient's will to survive and to regain mobility must be encouraged and maintained. A body without a spirit cannot maintain life and usefulness. The patient must find a niche for himself in society and he must become independent.

Mr. Martin needed assistance in the great adjustment to be made from the active life of an outdoor laborer to confinement to a wheel chair or possible use of crutches. Naturally, he experienced a period of mental strain and frustration during which he required constant encouragement, reassurance, understanding, patience and tolerance. At times he was very depressed and withdrawn, and the nurses had to be understanding and considerate. He needed someone who was genuinely interested in his predicament to whom he could confide his troubles and with whom he could discuss his mixed-up emotions. It was unfortunate that his family, particularly his mother, was not available, because of distance, to share this support with the nurses. He had to resolve any feelings of revenge, suicidal intent or self-pity. He must learn to live with himself to regain self-confidence, to build for his future in society once more.

In this day and age there is a greater opportunity for quicker and more effective return to active life through the science and "psychology" of rehabilitation. Much can be done for the paraplegic patients in teaching them to walk again with braces or crutches. A large percentage of those with serious spinal injuries can learn to walk with crutches and a great many can become self-supporting.

The hospital welfare workers can help handicapped people who are in need of financial assistance and employment. Those who are found to require such aid should be referred to the social service department as soon as possible. Other services that assist the handicapped include the local rehabilitation society for the physically handicapped. This society's purpose is fourfold:

1. Guidance in physical restoration to reduce or remedy the disability;
2. instruction and training for suitable occupations;
3. provision of opportunities for gainful employment;
4. provision of companionship for the handicapped and recreational opportunities suited to their needs.

The National Employment Service (under the Department of Labor) has a special placement section to provide and meet the vocational guidance and placement needs of the handicapped. There is a voluntary national foundation called The Canadian Paraplegic Association that undertakes to provide treatment, care and financial assistance to the paraplegic. This association re-

ceives its funds from the individual provinces. The Canadian Vocational Training Service under the sponsorship of the Department of Education aids the handicapped to become trained in some suitable type of vocation. Mr. Martin was informed that such services and aid were available to him so that he did not need to become upset over financial worries, in particular, and could plan for the future with greater ease and confidence.

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The Scope of Professional Nursing

LUCY D. WILLIS, M.A.

Every year hundreds of young graduates repeat "I solemnly pledge myself before God and in the presence of this assembly to pass my life in purity and to practice my profession faithfully . . ." But what is my profession? What is nursing?

SOME WAG HAS SAID "nursing is what nurses do." This might be funny if it was not so close to the truth. Many times in the past few years I, like many of you, have collided head on with this question. A young applicant said recently "Tell me, what is nursing? Someone told me the nurses' aid does everything for the patient now. Is nursing worth while entering if I want to help other people?"

LUCY D. WILLIS

Miss Willis is assistant professor at the school of nursing, University of Saskatchewan.

As president of a provincial nursing association questions came to me from members, who apparently were not sure of what their job entailed. "Nursing is what nurses do" is a dangerous answer to this type of question. "Is it all right for me to give an anesthetic?" or "start an intravenous?" or "do immunizations?" "Can I say an infectious case cannot be admitted to the only single room near the nursery?" Associations also have to answer less personal questions. "Is this institute in a nursing problem area or does it belong to management and the hospital association?" "Is this a legitimate use to make of funds held in trust for our members?" "Is this extension of nursing services within our legal territory? Are nurses protected when they do this thing?" Haven't you often wished for a rule, a list, a delineation, or a limitation?

Unfortunately, in Canada nursing is not clearly defined legally. None of the nurse practice acts tell what nursing is. Fidler and Gray state:

> At present, we have to rely on the somewhat vague generally recognized conception of nursing practice; and this

makes it necessary for the nurse at least to be clear on what nursing is not. Many things which it would be illegal for a nurse to do on her own responsibility are perfectly proper when done under a physician's direct supervision.[1]

and again:

> There is an increasing tendency for nurses, especially in small hospitals, to take over certain duties which have formerly been done only by doctors. The commonest of these is intravenous injection. The fact that it is quite easy to train a nurse in the technique of this treatment is not the point; nor is a shortage of doctors the responsibility of the nursing profession.[2]

The "vague generally recognized conception of nursing practice" probably fits into the following description. The doctor diagnoses and treats the patient. He delegates to the nurse the carrying out of some of the treatments. The nurse must do these with care and prudence. The nurse has other functions relating to the comfort, general hygiene and routine needs of the patient, which, except in unusual situations related to the diagnosis, are done independently of the doctor's specific orders. Frequently, but not universally, the nurse does independent health teaching, including specific, non-therapeutic health care related to the illness. She is expected to manage the patient's daily regime so that the highest possible level of function of all body organs and tissues is preserved. With increasing frequency and to a greater extent she is expected to carry through, if not initiate, rehabilitative measures. The many qualifying words in this description point up the need for clearer definition.

Though none of the Canadian Nurse Practice Acts define nursing, some of the American ones do. Creighton quotes one of these — the Arkansas Act — as representative.

> A person practices nursing . . . who . . . performs any professional service requiring the application of principles of nursing based on biologic, physical and social sciences, such as responsible supervision of a patient requiring skill in observation of symptoms and reactions and the accurate recording of the facts, and carrying out of treatments and medications as prescribed by a licensed physician, and the application of such procedures as involve understanding of cause and effect in order to safeguard the life and health of a patient and others.[3]

Statements issued by formal assemblies give further clarification as to the nature of nursing. The preamble to the International Code of Nursing Ethics, adopted in 1953 by the International Council of Nurses states:

> Professional nurses minister to the sick, assume responsibility for creating a physical, social, and spiritual environment which will be conducive to recovery, and stress the prevention of illness and promotion of health by teaching and example. They render health service to the individual, the family, and the community and coordinate their services with members of other health professions.

At the Technical Discussions of the World Health Organization, held in Geneva, May 1956, recognition was given to the fact that each country should prepare its own statement of nursing function. Those assembled agreed that there were five essential functions of professional nursing.

1. Giving skilled nursing care to the sick and disabled in accordance with the physical, emotional and spiritual needs of the patient whether that care is given in hospitals, homes, schools or industries.

2. Serving as a health teacher or counsellor to patients and families in their homes, in hospitals or sanatoria, in schools or industries. Because of her extensive and intimate contact with patients and families, the nurse usually has the confidence of the family and is in a strategic position to put scientific information into simple language which will be understood, accepted and put into practice.

3. Making accurate observations of physical and emotional situations and conditions which have a significant bearing on the health problem and communicating those observations to other members of the health team, or to other agencies having responsibility for that particular situation. Thus, the nurse is a very valuable liaison between the patient and the physician, the research scientist, the sanitarian, the social worker, the school teacher and the industrial foreman.

4. Selecting, training and giving guidance to auxiliary personnel who are

required to fulfil the nursing service needs of a hospital or public agency. This also involves an evaluation of the nursing needs of a particular patient and assigning personnel in accordance with the needs of that patient at a particular time.

5. Participating with other members of the team in analyzing the health needs, determining the services needed, and in planning the construction of facilities and the equipment needed to carry out those services effectively.[4]

Somewhat similar, but slightly more specific statements of function have been made by the Joint Commission on Nursing (U.S.A.) in 1953,[5] and by the American Nurses' Association in 1954.[6] The Joint Commission represents an organized and official attempt to get an opinion on nursing function from various experts with vested interests in nursing, for example the American Medical Association and the American Hospital Association.

Somewhat different results came from asking individual consumers of nursing for their views of what the nurse's role should be. One hospital administrator headed an article "Wanted, Managers in Nursing."[7] A doctor, who is a hospital administrator, and his assistant think the nurse should be prepared to:

carry out involved nursing procedures,

supervise as a team-leader in understanding patient needs and in planning and providing for bedside care,

supervise as head nurse, supervisor or administrator,

teach,

assume more medical and technical duties[8]

—whatever that means! We hope they do not expect this to be done in a basic three-year hospital program.

Another hospital administrator asks only that the nurse have a sense of loyalty so that she won't wander aimlessly from hospital to hospital, and pride in the quality of her work so that she won't "vegetate" if she does stay in one spot.

Historically the picture of nursing is well known. Nutting and Dock describe Phoebe, the first deaconess, in the following manner:

Her journey to Rome, the statement of St. Paul "she hath been a succourer of many and of myself also," with other historical data, point to her as having been a woman of importance and dignity.[9]

Later in the same volume, and centuries later in history, the authors describe the nurse in the dark ages. "The drunken and untrustworthy Gamp was the only professional nurse."[10]

We prefer to think of ourselves as far removed from the nurses of those heartless and repulsive days. But sociologists have a habit of showing us that our roots are really in the past, and that our present status, if not our behavior, is based on long forgotten social conditions. In a very provocative article, George Devereux traces his observations and interpretation of how nursing grew into its present role. He claims that it is built upon the structure of woman's role in the Victorian age — her dependency on direction from the man (female nurse — male doctor), her suitability for menial and manual work (housekeeping and similar work), her tendency to achieve status through good works (the "angel" nurse willing to glory in drudgery on behalf of the helpless). This resulted in trained incompetence, denial of intellectual initiative and subordination to the doctor being recognized as characteristics of nurses as a group. In addition, he contends that the true meaning of the word "nurse" was overlooked. The same word is used for care of the infant and of the ill because both are physically and psychologically dependent. The emotional value of the nurse was ignored. She is pictured as schooled in the obsessive ritual of sterilizing nipples and bottles as a substitute for breast feeding and fondling, or busy with the "swabbing of floors and throats." He issues a plea that the cold sterile atmosphere of the hospital be eliminated, that warmth and affection take its place through liberation of the nurse's capacity to love.[11]

The upgrading of nursing began on a large scale with the enlightened, energetic and dominating Miss Nightingale. Physical and environmental care was literally revolutionized. The nurse became a respectable person! Miss Nightingale's intelligence and drive produced plans that were often stupefying in their magnitude for her colleagues or those in high places whom she influenced so effectively. Yet one

can see supportive evidence for Devereux's analysis in her writings:

> discipline is the essence of training[12]
>
> and
>
> . . . God, no doubt, gives us the required patience and steadfastness to continue in our "blessed drudgery," which is the discipline He sees best for most of us.[13]

Florence Nightingale was the founder of modern nursing. But what is the modern nurse of today doing, and what do her leaders claim that she should be doing? Nurse educators give us their picture of the nurse in the curricula they provide. Braced with an elementary but fairly adequate knowledge of anatomy, physiology, microbiology, nutrition and pharmacology, and a nodding acquaintance with psychology and sociology, she is prepared to give hygienic nursing care to patients of all ages and to carry through, safely and effectively, certain largely technical procedures with the required skill, observation and judgment. Hopefully, she will consider the patient as a "whole person"; will be motivated to learn something about his background, his diagnosis and prognosis; and, keeping all this in mind, will make reasonable plans for his care and for teaching him some of the things that will help him to manage his health better in the future. She knows something of community health and welfare resources. She is able to nurse a patient at any hour of the day or night. She knows what a clean room looks like. She has probably learned a little bit about administration through her experiences, as a senior student, and something of how to be a leader and how to present a clinic or "speak in public."

Nursing service administrators give us the picture of the nurse-octopus — many arms reaching out to accomplish a multitude of loosely related duties. The Hospital Nursing Service Manual[14] listed 21 functions for the director of nursing service, 14 for the supervisor, and 15 for the head nurse. These ranged all the way from initiating policy formation to securing, storing, distributing (and no doubt counting) supplies.

Reissman and Rohrer, as outsiders looking in, describe the hospital nurse's duties as teacher, administrator and team manager, specialized in a clinical area. They say that the family is largely outside her grasp; that she is no longer responsible for total patient care since changes have shifted responsibility for dietary and housekeeping services. She is "the hub rather than the whole wheel" in nursing, and must *fit in*, rather than *control*.[15]

The head nurse, with increasing frequency, is described as a coordinator, providing for smooth interlocking of various patient care services. This predicament, in which the nurse finds herself required to take over responsibility for the "situation" which other professional workers, including that top authority, the doctor, simply visit, has been commented on by social scientists. A statement in Fidler and Gray should provide food for much thought on the matter. "It is his (the doctor's) orders that she (the nurse) has contracted to accept and carry out, and she must be satisfied that any measures which other workers suggest for her collaboration are, in fact, his delegated orders."[16] One wonders what the legal interpretation of "her collaboration" might be in the event that harm came to a patient through inadequate definition or understanding of function.

Frances Reiter Kreuter clarifies the issue of function somewhat by differentiating between nursing practice — the large field — and nursing care as a component of it.[17] Many within and outside the profession feel that the nurse in the hospital is lost to the patient. They point out that a large percentage of direct nursing care is being given by auxiliary staff, while the nurse does other things. In general, complaints are lodged against record keeping, preparing requisitions, and looking after supplies. Much, of course, has been done to reduce non-nursing duties, but much more can be done.

Close and continuous observation of the patient and passing on information in meaningful form has always been one of the primary functions of the nurse. Good communication regarding the patient's condition is dependent on knowing what is important and how to state it so that it will convey the idea accurately. The ability and knowledge required to do this is often well beyond that of an auxiliary worker and, quite correctly, is the job of the more senior worker. Certainly, in both hospitals

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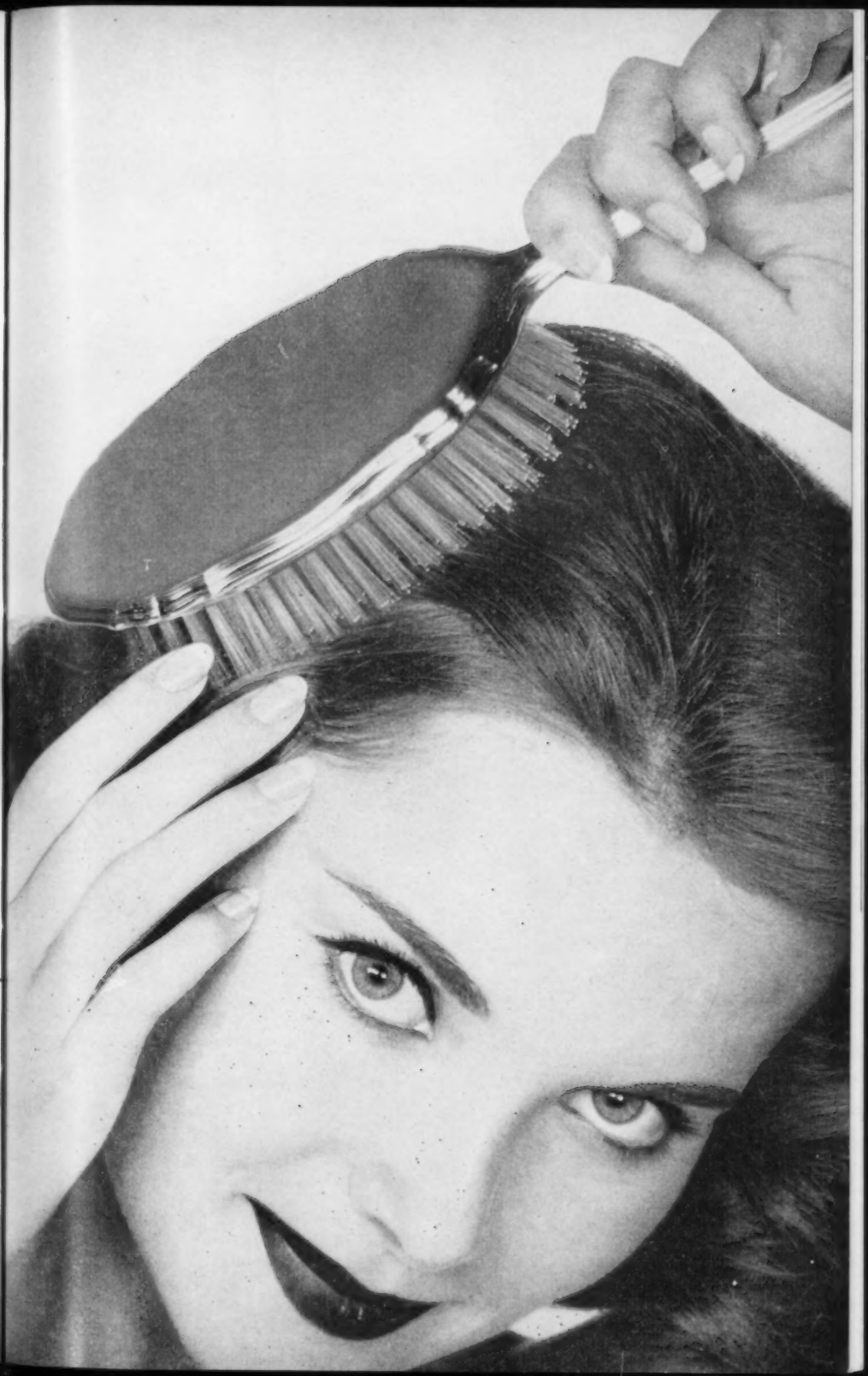

and other agencies, non-nursing duties that have little or no bearing on the quality of nursing care should be given over to other workers less taxed by shortages of personnel and/or differently prepared.

However, in hospital, much of the administrative and managerial work is so closely tied in with quality of care that it is inconceivable that this part of it be given to any other worker. Whether we should retain the title of nurse for those who are several stages removed from direct patient care is worthy of some thought. Hyphenated titles may be in order!

In a study of the nursing team, one of the suggested functions of the team leader was to use her knowledge to influence the course of nursing care. It was readily recognized that, even when the team leader had limited actual physical contact with the patient, the guidance, supervision and assistance that she gave to the less prepared members of the nursing team were significant in improving the quality of care, both specifically in a single care item, and through helping the team member fill her role more adequately. Surely, in this function the team leader is "nursing," just as the public health nurse is "nursing" when she teaches relatives to care for a family member.

There is an exciting and positive side to professional nursing that is making inroads in our thinking. I refer to the area of dynamic nurse-patient relations. It is not new to think and talk about the personal qualities of the nurse. She has been described as kind, gentle, thoughtful, interested in her patient's welfare. Applicants to schools of nursing most commonly list as their primary motives a desire to help others, to relieve their suffering, to work with people. This suggests that this is the role in which they see the nurse. Lesser and Keane, in a 1956 study, report that in interviews with 66 maternity patients, before and after delivery, the most prominently expressed need was for a warm, sustaining, human presence throughout labor. Many of them saw the nurse as the obvious person to meet this need.[18]

Peplau and Kreuter go well beyond the concept of the kindly, sustaining nurse as the ultimate in good care. Peplau says that nursing is a goal-directed process, educative and therapeutic in that it leads the patient on to more effective, more satisfying and more mature behavior.[19] Kreuter suggests that the quality of nursing can be measured by the "movement of patients" from dependence through independence to personal wholeness or integrity. These developments, she states, are a product of the interpersonal relationship and are dependent on the level of communication between the nurse and patient.[20] The patient can only move if the situation permits it. Public health nurses, and more recently, hospital nurses, have included the patient in the plan of care, so that it becomes truly the "patient's plan." The approach outlined above would entail the nurse assessing, during contact with the patient, what his level of personality development is. She sets the stage so that, in his experience, personal growth along desirable lines takes place.

I see these as some of the most significant and forwarding-looking statements being made about nursing today. Over 40 years ago, Annie W. Goodrich said that we must look, not at the institutions, but at community needs to determine the essential functions of nursing.[21] Our most pressing health problem today is mental and emotional illness. As with other health problems, cure is not the economical approach. Helping people to solve their emotional, social and physical problems so that they can effectively and satisfyingly face the problems of their everyday living, can do a great deal to stabilize home, community and national life. Nurses represent the largest force in the health worker field. Universal, or nearly universal coverage, through prepaid health and sickness insurance already gives every promise of skyrocketing costs of hospitalization and other kinds of care. Note also that most schemes, to date, exclude mental illness from coverage.

Devereux, speaking of the increasing number of collegiate schools of nursing established after 1930, said he did not view this as the dawn of a new era, but rather as the decline of the old. Florence Nightingale began a new era by improving sanitary and environmental conditions in hospitals, the physical care of patients, and by estab-

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lishing an educational system. Now 100 years after her school opened, are we ready to launch a new era, one in which the professional nurse's most significant role will be establishing relationships that promote personal growth of the patient? This will be nursing for the future, for the *patient's* future.

May I conclude with these few observations. The challenge to nurses has never been greater than it is today. The opportunity to obtain intelligent, highly-motivated, enthusiastic students has also never been greater. We can go on, passively accepting whatever additional technical procedures the medical profession sees fit to hand down to us, and just as placidly relinquishing some of our less attractive ones to auxiliary nurses. We can do this, though we may always be on the brink of illegal practice, or of endangering patients through limited knowledge or understanding. We could probably become coordinators, or perhaps white-uniformed traffic policemen if we wish, regulating the coming and going of those who "do things to the patient." This has been called "controlling the situation." Or we can say that the unique role of the nurse is in the warmth of her personal, supporting presence, ministering to the patient during the time when he needs care, so that while returning to physical or mental health, he also, through an experience of personal growth, reaches or returns to satisfying levels of social and economic effectiveness. Is this what we want to do? Is this what we are prepared to do? Is this nursing?

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The stages and signs in anesthesia have been summarized on a color chart, with accompanying illustrations of the signs to observe in a patient under anesthesia. Reactions to various anesthetic agents and adjuvants employed today are included. The chart is available through the National Cylinder Gas Division of Chemetron Corporation, 840 North Michigan Ave., Chicago 11, Illinois.

* * *

We have just enough religion to make us hate, but not enough to make us love one another. — SWIFT

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SPECIAL AWARD

Elizabeth Lawrie Smellie, C.B.E., R.R.C., LL.D., one of the most outstanding Canadian nurses and upon whom many honors have been conferred, has been given the Red Chevron Award for 1960. Presented on the anniversary of the second Battle of Ypres, the citation read:

To Colonel Elizabeth Lawrie Smellie, C.B.E., R.R.C., LL.D.

The Red Chevron Club of Ottawa and District being fully conscious of your long & devoted service to fellow Canadians is proud and happy to welcome you as an honoured guest on this the 45th Anniversary of the Second Battle of Ypres.

Your inspiring leadership, in War and Peace, through the organization & conduct of Nursing Care for the wounded, the ill, and the infirm, has been of paramount importance and credit to Canada and yourself.

You have brought comfort and healing to many thousands. A sound knowledge of your profession, coupled with a true appreciation of human needs; a sympathetic and ready understanding, and a most gracious manner, have won for you the admiration and friendship of those you have served so faithfully and so well.

Sensitive of your many accomplishments & outstanding contributions, we wish you long & happy memories & we ask you to accept this modest & inadequate expression of our deep gratitude for all that you have done.

J. L. McCULLOUGH
President

Ottawa, Ontario,
April 22nd, 1960.

(Karsh)

ELIZABETH L. SMELLIE

Miss Smellie decided to continue her residence in Ottawa following her retirement from her position as Director in Chief of the Victorian Order of Nurses for Canada.

The substance in poison ivy, poison oak and poison sumac that causes the rash is called *urushiol.* It is a powerful substance that permeates leaves, stem, roots and fruit. It is invisible and can be transferred even when the plant has withered — it can go through a glove to your skin.

Many people think that they are immune to poison ivy, but they are actually building up sensitivity with each exposure.

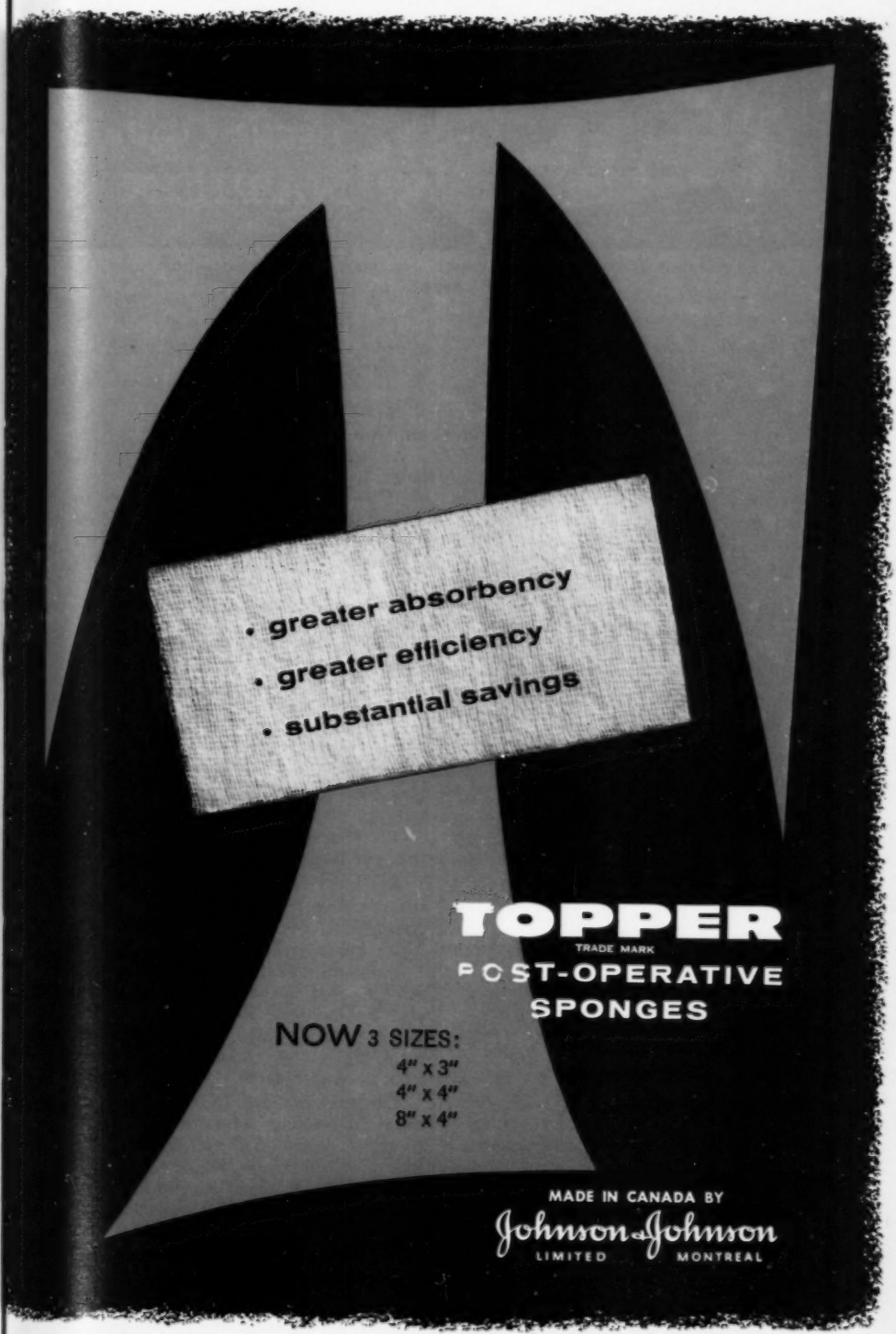
A development reported to the American Medical Association offered . . . built-in immunity. Protection was possible in 95 per cent of cases by oral administration of Aqua Ivy Tablets in advance of the season. These may be purchased at drug stores, without a prescription. There is no toxicity.

— Central Feature News, Inc.

Making Health Matter is the title of the 1960 summer school in health education, which will take place at the Froebel Education Institute in London, England, August 9-19. Forums have been devised at which experts will present short papers as a basis for discussion of such topics as: juvenile delinquency, the community care of the mentally ill, recent progress in medicine and the problems of public health workers.

An experimental group discussion session is planned, at which an attempt will be made to measure the effectiveness of group discussion in attitude-changing.

Application to attend should be made to the Medical Director, The Central Council for Health Education, Tavistock House, Tavistock Square, London, W.C.1, England.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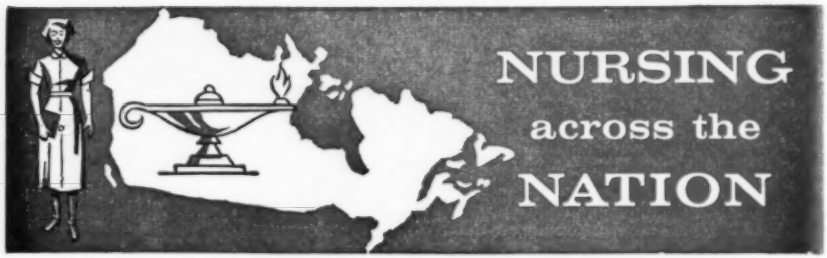


PREPARED IN YOUR NATIONAL OFFICE, CANADIAN NURSES' ASSOCIATION, 74 STANLEY AVENUE, OTTAWA

ILO publishes report

The report of the study of "Employment and Conditions of Work of Nurses" is now available through the Canadian branch office of the International Labor Office, 202 Queen Street, Ottawa 4. Miss Margretha Kruse, executive secretary, Danish Council of Nurses was appointed by the ILO to assist with this study and its contents were used as a basis for discussions at the meeting of the Ad Hoc Committee on Conditions of Work and Employment of Nurses held in Geneva, October, 1958. The study is concerned with the employment and working conditions of professional nurses and auxiliary nursing personnel. As student nurses are not considered employees they do not come within the scope of this study.

Questionnaires were circulated to 67 countries and the material presented in the report covers 56 countries in all parts of the world. Included in the report are the conclusions of the ILO Ad Hoc Meeting on Conditions of Work and Employment of Nurses.

This study is available in both French and English and should prove of value to those responsible for nursing administration and service.

International Nursing Review

The ICN reports that its official publication *International Nursing Review* will now be published six times a year instead of quarterly. The subscription price is $4.50 a year.

Copies of the July 1959 jubilee issue, a valuable record of 60 years of ICN history, are still available. Nurses who missed this issue may obtain it by writing to *The International Nursing Review*, 1 Dean Trench Street, Westminster, London, S.W.1., England — the price $1.50 a copy.

WHO Conference on Study Abroad

A large number of people contributed to the WHO-sponsored conference held in Geneva last October to find answers to the question — How can programs for students in countries other than their own be made more meaningful? Three kinds of problems of international students were considered by the conferees:

problems in preparation for study abroad;

those met during the stay in another country;

the problems that arise on the return home.

A complete report of the conference is to be published this year by the WHO.

RCAF Nurses' Association—Metz

An interesting letter arrived in National Office from the RCAF Nurses' Association in Metz. In spite of the heavy changeover of staff, this organization continues to develop. Its activity is supported by about 24 nurses, and also by many of the RCAF doctors. Apart from several interesting lectures from doctors, the main activities have been in two areas.

The first is Civil Defence. With so many dependent wives and children there, an active Civil Defence Organization is in operation, of which the Association is a part. Aside from a series of lectures for nurses on first aid, nuclear first aid and emergency obstetrics, the nurses are repeating a form of these lectures to the wives. Another project, under the direction of

the RCAF, is the staffing of a Well Baby Clinic, which is greatly needed. Two other RCAF stations have developed active Nurses' Associations. Now Canadian nurses in Europe with the RCAF are quite well organized. The new Executive of the Association in Metz is as follows:

> Mrs. M. Thompson, president; Mrs. H. Courtney, chairman of program; Mrs. M. Bowes, vice-president; Mrs. E. Urquhart, chairman of welfare; Mrs. J. McLellan, secretary; Mrs. L. Soper, chairman of refreshments; Mrs. D. McLean, treasurer. The address of the Association is: HQ No. 1, Air Division RCAF, Canadian Armed Forces Europe.

WHCCY

Over 7,600 delegates registered in Washington for the Golden Anniversary White House Conference on Children and Youth. Included were 500 international delegates from 73 countries. M. PEARL STIVER, general secretary and F. LILLIAN CAMPION, nursing secretary, CNA were honored to receive the President's invitation to attend. Every ten years during the century, such a conference has been held. The purpose of the 1960 conference was

> to promote opportunities for children and youth to realize their full potential for a creative life in freedom and dignity.

The Conference opened on Sunday evening with 12,000 people filling the William P. Cole Students' Activities Building, University of Maryland, to hear the President of the United States give an address. An impressive ceremony — the Presentation of the Colors — by a combined Armed Services Color Guard, the singing of the US National Anthem by William Warfield, the singing of the Milton Hershy Glee Club, and the music of the United States Marine Band made this a memorable evening.

Five concurrent Theme Assemblies were held each morning of the first three days. Speakers at the Assemblies approved our ideals and values in this changing world on the first day; assessed the impact of today's economic, social and cultural factors on children and youth on the second day; and on the third day drew attention to the effects of science, technology, population pressure and world events on children and youth.

The Assemblies were divided into eighteen concurrent forums for the second half of each morning. In the afternoons 210 workshops, of about 30 participants each, met to discuss the material and information developed in pre-conference preparation and publications and from the assemblies and forums.

On Thursday, the forums met to consider proposals developed in the work groups. The action was reported at the closing general session, held on Friday morning. However, because of the large number of recommendations, proposals and general statements (1600) submitted, the committee responsible found it impossible to have a concise summary prepared although they worked until 3:00 A.M. Therefore, these will not be available until the Report of the Conference is published. We shall await this publication with interest. It should be studied by all those interested in children and youth.

At the close of each conference, committees are set up and planning begins for the next one. The ease with which the conference proceeded pointed up the genius of the Americans in planning and organization.

International Visitors

CNA had the privilege of welcoming to Canada, Miss ALICE C. SHER, assistant general secretary of the ICN at the Biennial Meeting in Halifax, after which her plans included visits to the Provincial associations in several provinces. We look forward to receiving Miss Sher at National Office in Ottawa during her tour of Canada.

Australia was also represented at the Biennial Meeting, by Miss C. SHEILA KIRK, nursing executive officer of Hospitals and Charities Commission in Melbourne. Following her attendance at the ICN seminar in New Delhi, India, Miss Kirk was granted a Kellogg Foundation Scholarship for overseas study. During this month she will be visiting Saskatoon and Toronto for observation and consultation in the following areas: Regional Hospital Schemes, Provincial Health Programs, Nursing Service Administration and Nursing Education programs.

Provincial Annual Meetings

As you peruse these pages, some of the staff in National Office have returned to their desks, some have gone on holiday following the Biennial Meeting. It was a wonderful meeting, wasn't it? We enjoyed particularly the opportunity it afforded us to meet so many nurses from across Canada.

There are many other ways in which National Office staff can meet CNA members. One is through the kind invitations extended to us to attend provincial annual meetings. During the past few months, M. Pearl Stiver, has attended and spoken at annual meetings of the NBARN and the ARNN., F. Lillian Campion spoke at meetings of the AARN and the RNABC. Both nurses returned with glowing reports of their reception, and the many activities that the nurses of these provinces are undertaking to improve nursing service and nursing education.

CNA Publications

Nurses across Canada will be pleased to learn that the *Report of the Pilot Project for Evaluation of Schools of Nursing* is now available in French and English. The price is $3.00 per copy.

The First Fifty Years — a record of CNA history, has been revised and is now available in both French and English.

The report of the ICN Board of Directors meeting, held in Helsinki July 1959, presented by M. Pearl Stiver to the Executive Committee, has been mimeographed and is available in English.

Facts and Figures about Nursing in Canada is available in English. This booklet is a revision of the former CNA publication "General Information and Statistical Data."

These three publications are available in quantity, and without charge.

Also available is the manual *"Guide for Head Nurses in Hospitals"* and a statement on *Job Satisfaction*. Both these publications are available in French and English.

Because of the advent of these new publications, National Office is presently preparing a new publications list. This list will be published later in the *Journal*.

O.R. Safety Code

The nursing secretary, F. Lillian Campion, represented the CNA at a meeting of the Canadian Standards Association Committee on Hospital Hazards. Four subcommittees presented reports on various aspects of a safety code for hospital operating room hazards.

Most of the committee members are technical experts, including architects, engineers, fire underwriters and fire marshals. There are also doctors and hospital administrators. Federal government departments and the National Research Council are represented as are such bodies as Canadian Nurses' Association, Canadian Hospital Association, Association of Canadian Fire Marshals, Underwriters Laboratories of Canada and the Royal Architectural Institute of Canada.

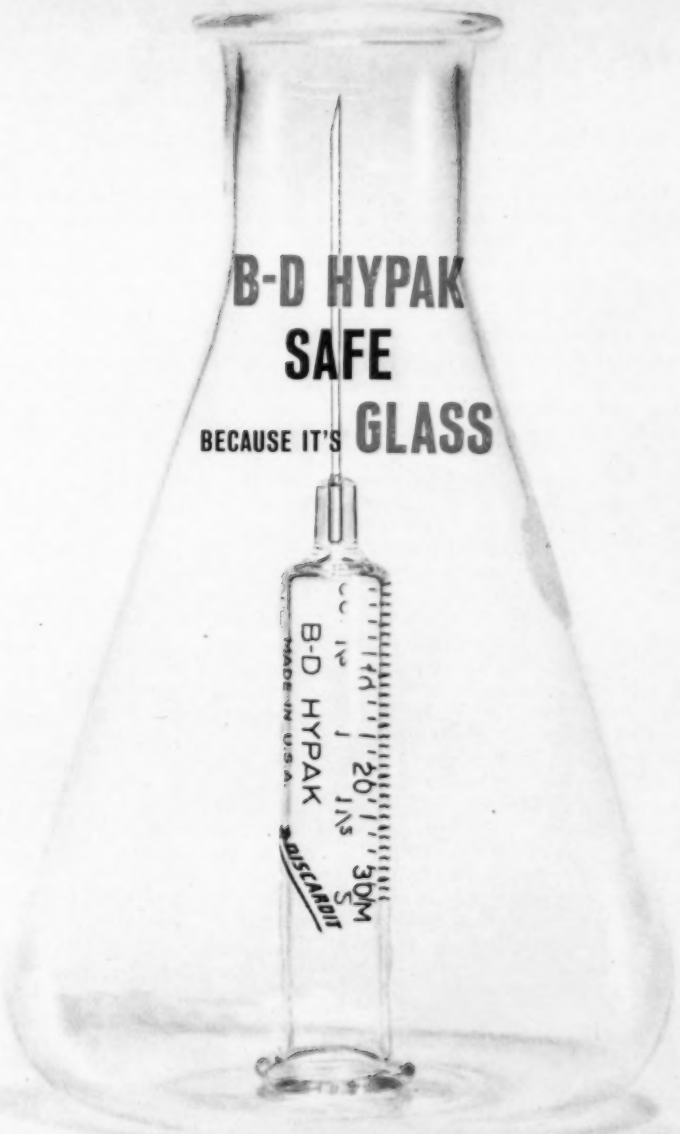
The discussions for the most part were quite technical, and one became a little confused with ohms, amperes, volts, potential arcs, KVA and sparks. Nevertheless, there was much that was of concern to nurses working in operating rooms. Some less technical items were: most explosions are due to static sparks — those caused by electrical equipment are rare. Ether is most hazardous and a very small amount can produce an explosive mixture. The safe storage of anesthetic gases and oxidizing agents was reviewed.

There was considerable discussion about the use of the term "shall" and "should," that is, whether there should be mandatory statements or recommendations. It was recognized that no enforcement of the code was possible until a provincial authority adopted it.

The editing committee hopes to have the code ready for printing in September. All nurses working in operating rooms will want to study it. A committee on interpretations will be set up to which all questions and problems will be referred.

A prejudice is a vagrant opinion without visible means of support. — AMBROSE BIERCE

To understand is to pardon.
—MADAME DE STAEL



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A HAND OUTSTRETCHED

JOSEPHINE KURIATNYK

Fifty-three years old, unhappy, alone in the world, sorely afflicted by a terminal illness — what an opportunity for a compassionate nurse to give of herself in comprehensive nursing care!

A TAXI APPROACHED the hospital's emergency entrance at a speed that defied the city's laws. The driver was very anxious to get his fare to a doctor. He helped the orderly and nurse get the lady into a wheelchair and sighed with relief when his responsibility was over.

Tessy Arno had been at a neighborhood shopping center when suddenly she became extremely short of breath. By the time she reached the hospital the dyspnea had decreased somewhat, but her pale, drawn face was full of fear.

She was admitted immediately and examined by an interne. Her emaciated face, neck and arms were in marked contrast to the lower part of her body. Her abdomen was full of fluid, easily felt on palpation, and pitting edema had risen from her feet to the level of her sacrum. In an effort to relieve her immediate distress the doctor performed an abdominal paracentesis, obtaining nearly 4000 cc. of fluid. A specimen of peritoneal tissue was taken for pathological study. A few days later the results indicated metastatic seeding of the peritoneal cavity, probably from a primary ovarian malignancy.

Miss Arno noticed the distention over two years ago. She hesitated to go to a doctor as she did not understand what was wrong with her. Ever since she came to Canada from Russia in 1927 she had worked as a cook. She felt that she had always been treated as an inferior by the society in which she lived. She had never made any friends in Canada. When her abdomen first began to enlarge she knew of no one to whom she could turn for help. Because she could not explain her bloated appearance people reached mistaken conclusions and she soon began to think that she must be peculiar.

During this two-year period she was ill on several occasions. Twice she was forced to give up her position and live on her savings. Eventually, about a year ago, she had gone to see a doctor. He did a paracentesis and advised an operation which was refused. Fear, lack of knowledge and moral support were to cost her her life.

Three months ago she gave up her position for the last time. She felt she was not wanted because she was ill and went to live in the Y.W.C.A. She deposited $295 for safekeeping when she entered hospital — the balance of her life savings!

The objectives of nursing care for Miss Arno were to alleviate anxiety and apprehension, to keep her as comfortable as possible and to prevent any complications which would add to her distress.

The day following admission she was to have her chest and abdomen x-rayed. When I explained the procedure to her she became very frightened. Although she had lived alone and kept to herself for years, her fear of going to the x-ray department alone was very real. With permission, I accompanied her. She insisted that I hold her hand on the way to the department and remain with her while the films were being taken. She needed help and encouragement to attain the correct positioning for the x-rays as it was extremely difficult for her to lie in a dorsal recumbent position.

The same fear of the unknown was evident when I explained the procedure of electrocardiograph to her. When she knew I would remain with her while it was being done, she seemed more at ease.

Many factors made good skin care essential — edema, poor circulation

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Miss Kuriatnyk was a first-year student at the Edmonton General Hospital when this study was done. It was awarded honorable mention in the recent Macmillan Award competition.

due to congestive failure, and constant positioning on the right side. I gave her a complete bed bath each morning. At first, I encouraged her to do part of her own bath, but before long she was unable to help herself. Following the bath, Zincofax ointment was applied to her back, elbows, feet, buttocks and thighs. Massage with Zincofax, cleanliness and positioning successfully prevented decubitus ulcers.

Miss Arno was encouraged to get up but movement caused such discomfort she preferred to lie quietly in bed. During the morning bath, her joints were put through the full range of motion. She learned how to tighten and relax her leg muscles to prevent phlebitis. Deep breathing exercises, to increase lung expansion, helped to prevent hypostatic pneumonia.

Each afternoon she was given a sponge bath followed by re-application of Zincofax. She was turned every two hours — but only after much discomfort and encouragement. She seemed to realize we were trying to do what we could to help her. As the illness progressed she would lie only on her right side — movement became unbearable.

Her teeth had never been properly cared for and she was nauseated frequently; special mouth hygiene was welcomed.

Her appetite was poor, as it had been for many months. Her diet at home was totally inadequate from a nutritional standpoint. She had no interest in food.

She had lived in a small room and done her cooking on a hot plate. She disliked salads and ate meat only on rare occasions. With only herself to cook for she spent a minimum of money and time on food preparation.

The high-protein, high-calorie hospital diet was very different from anything she had ever known. In her present condition it was impossible for her to change her habits — she refused her food repeatedly. Miss Arno prepared a sample listing of what she had been accustomed to eating. It was hoped that if she was served exactly what she requested she would eat something. The list was sent to the diet kitchen and she received selections from the list at each meal. She still only "picked" and often refused the food completely.

Although she understood the necessity of eating in order to maintain her strength, she made little effort. She attributed her consistent lack of appetite to bouts of nausea, indigestion and "gas." She refused a vitamin preparation and three different cough mixtures because they nauseated her.

There was such a helplessness about this patient. She said that there was no one who cared about her. She was completely alone — without family or friends. She was physically miserable and emotionally without support. She seemed to care as little about her recovery as she felt anyone else did. Recovery meant a return to her lonely life with even less financial security than prior to hospitalization.

Although she was so ill, Miss Arno rebuffed spiritual assistance. A non-practising Lutheran, she refused to see the clergyman of her faith on his hospital visits. On one occasion when he was visiting in her room, he asked her if he was a minister of her faith — she replied that he wasn't.

Medical assistance had been available for this patient when she first sought it. If she had submitted to surgery then, her chances of recovery would have been reasonably good. The Canadian Cancer Society would have been available for financial assistance during hospitalization and rehabilitation. The disease is now terminal.

Society has let one of its members down. A composite of factors — her lonely life, without friends or support from her employers, her language difficulties, her lack of understanding of her illness, and the lack of awareness of her needs on the part of those who knew her — caused her to withdraw and disregard her physician's advice. The result — a steady decline to her present tragic state.

If you want to know what God thinks of money, look at the people he gives it to.
— ANON

Born with the gift of laughter and a sense that the world was mad.
— RAPHAEL SABATINI

Social and Mental Health

THÉRÈSE LORIOT

The term "social health" implies that an individual in the community must be considered as a total being. Otherwise, a public health nurse would not be able to render total service.

Although interest in matters of health and mental hygiene has increased markedly during latter years this very broad field is still difficult to define. The aim of mental health, dealt with here from the point of view of the public health nurse, rests especially in knowing how to track down in individuals within a community all precursory signs of emotional or mental disturbance. By being able to expose these signs at the very beginning, it will then be less difficult to discover the cause of them, and as a result, to prevent a more serious crisis.

In certain situations, the psychic strength of an individual is weakened. This phase can be more or less critical, depending on the factors which have induced it and the value of the support received at the time. These latter will determine whether or not the end result will be sure. It is during this early phase that the public health nurse will be able to function most profitably. She will direct her efforts towards building up healthy attitudes and healthy relationships between people, and will also contribute to preventing the appearance in society of new "carriers" of mental difficulties.

Without being constantly aware of it, the visiting nurse cooperates daily in observing and improving the mental state of her patients. While she goes about her routine duties, she willingly listents to individual or family problems and as necessary volunteers advice. Often she is the first professional person to come in contact with a family in which one of the members is in difficulty. Sometimes she is the one and only outsider to whom a confidence is entrusted.

Among the various members of a community with whom the nurse comes in contact is the mother of the family. The mother's influence is predominant in the family circle in the emotional and mental development of the child. Her influence begins during pregnancy when sensitivity is at a peak, when insecurity and anxiety can extend to the very first breath of the newborn. During pregnancy, biological processes can induce or stimulate the reappearance of former forgotten problems. For example, the relationships between a woman who is pregnant for the first time and her own mother may include misunderstandings that have never been cleared up. Pregnancy can bring to the surface personality weaknesses which could lead to emotional upsets. Former partially resolved problems suddenly come to life, mesh into the present situation and upset the pregnant woman if reassurance is not forthcoming. On the other hand, the revival of former conflicts can permit development towards true maturity or, if poorly acknowledged and accepted, can end in an abnormal attitude towards the unborn baby — unconscious rejection.

The varying moods common to expectant mothers require the nurse's understanding. She is the ideal one to help since her relationship with the mother is a very close one. She is accepted into the immediate family circle; she visits regularly during the course of the pregnancy, throughout the postpartum period and then according to the needs of the family.

In Great Britain and some other countries the nurse is called "Sister" with good reason. It is a symbolic term, where traditionally, the experienced, helpful nurse is looked upon as an elder sister. The nurse provides moral and professional support. She is sympathetic, understanding and interested. She accepts the mother as she is with her fears, her phobias and her idiosyncrasies. She explains, guides and enlists all available means of ad-

Miss Loriot, who has had special preparation in psychiatric nursing, wrote this article while she was a student at the School of Public Health, University of Montreal.

ditional support and affection for the mother. It has been said that the pregnant woman needs more affection in the same way that she requires additional vitamins and protein. This is particularly true in the latter stages of pregnancy. It is also recognized that the maternal instinct develops in proportion to the amount of attention and sympathy lavished upon the mother. Husband and family need intelligent guidance during this period. They need help in knowing what attitude to take; what the possible variations in the mother's moods may be and the inevitable reactions characteristic of pregnancy. Ignorance, fear, uncertainty and anxiety readily dissolve in the light of knowledge. Objective, frank discussion during a period of crisis induces return to normality.

Another person in similar physiological circumstances whom the nurse can help, encourage and guide towards social rehabilitation is the unmarried mother. The customs of modern occidental society have created the tendency to hide, either within the family or in special institutions, the birth of a baby who does not have a legal father. Very often the visiting nurse is the first person to whom the secret is confessed. The young girl herself tries to hide her condition for as long as possible and thus does not receive adequate medical supervision. The nurse can help to formulate a realistic plan in such situations. She can persuade the parents to face the facts. Maternity care must be decided upon. Often a private hospital is desired. Community resources such as adoption agencies and foster homes must be investigated. The extent to which the parents can contribute financial support and ensure security for the young woman must be determined. The agencies able to assist in her rehabilitation must be considered. All these factors form essential parts of this particular situation in our society.

The aging population is increasing year by year. Social legislation tends to lag behind the rapid progress of this era, consequently the problems of the aged are becoming progressively more complex. For instance, the retirement age is more or less fixed at 60-65 years. Too little attention is paid to whether or not the individual is capable of productive, profitable work at the level of his mental and physical capacities. Generally speaking, the 65-year-old man who must retire from active life to leave room for the younger men can be more adequately prepared technically. If his retirement has not been planned for, there is little left for him to do except to sit in his rocking chair by the fire. People who are still physically and intellectually alert at retirement age feel frustrated, humiliated and helpless. Left to themselves day after day, often with only a meagre pension after being accustomed to comfortable living, some of them become depressed and deteriorate very rapidly. The most tragic aspect is their tendency to feel that they are in the way; that they are not wanted; that no one understands them. This state of mind can cause anxieties, frustrations and misunderstandings with their associates.

The very elderly who are showing progressive signs of senility are sometimes sources of friction in families forced to live in crowded quarters. People are not always informed about the signs of degeneration that fall to the lot of the elderly. The aged, no longer like their former selves, cannot understand why their diet and way of living must be regulated. Loss of memory, one of the symptoms of regression, leads to forgetfulness of recent events while memories of earlier days fill their thoughts and create a special world for them that others often fail to understand. Their behavior is childlike and they must be watched over, guided and assisted in every way.

The intelligent nurse who is well-informed concerning local resources, will know how to go about encouraging and cheering up the elderly person and his family. She will be able to suggest agencies concerned particularly in developing new interests for retired persons. They are given opportunities to participate in work projects in keeping with their abilities and desires. Their leisure time is organized and social gatherings with others having similar interests are planned. For those who cannot be cared for at home, there are institutions housing persons of the same age level with similar problems. In these homes, although there could often be better organization of leisure

time and activities, the old people feel peacefully settled, surrounded by their own belongings and with their memories. A great deal more remains to be done in the fields of gerontology and geriatrics however, apart from consideration of mental aspects of the aging process. Medical supervision and nursing service in these institutions should be provided by a permanent, competent staff consisting of, at least, a doctor and a resident nurse.

The convalescent group and handicapped individuals who may have had a more or less prolonged period of hospitalization, are very often prey to emotional upsets. The duration and demands of convalescence; the degree and anticipated length of time of invalidism; the chances of cure; the difficulties inherent in rehabilitation — all of these factors are disturbing and present financial problems.

The nurse functions, as a rule, to support and protect emotional equilibrium; to aid in rehabilitation and to organize and carry out necessary nursing care. She must be alert to poor familial or social adjustment: to the appearance of neuroses or psychoses. In particular, she must be able to analyze a situation, form an opinion and refer to other sources of aid at the right time.

In our schools we find the personnel who are entrusted with the teaching program and with maintenance. Here, more than anywhere else, preventive measures against physical and mental illness seem to be more highly organized and faithfully carried out. With the cooperation of parents, administrative authorities and teaching personnel, a plan for the application and supervision of preventive and corrective measures can function full-time. Through screening, personality and behavior problems come to the attention of specialists. Segregation and guidance of the less-gifted and the mentally deficient are carried out systematically along approved scientific lines. The more-gifted, perhaps, form the group who still lack adequate supervision.

The function of the nurse within the educational setting is more complex. She acts as liaison between pupils, parents, administration, attending physicians, community agencies, clinics, hospitals, outpatient departments, dentists, social service, and even juvenile courts and correctional agencies. Fortunately, the latter relationship is a rarity.

Finally, there are the individuals including children who are presently under psychiatric care or who have been under it. They require long-term supervision and extensive social rehabilitation. In this instance, the nurse's main role, in addition to intelligent observation, will consist of keeping the doctor informed about the patient's condition and of instruction to the family concerning the nature of such illness. Sometimes the patient himself requires teaching, if he is capable of understanding and making his own decisions.

Another group of individuals encountered will be those who are acutely ill mentally. They need to have treatment as quickly as possible in order to prevent their present condition becoming worse and to offset a chronic state. Sometimes treatment in the doctor's office is enough. Others will require placement in psychiatric institutions and hospitalization for varying lengths of time.

Those who have returned home after treatment in a psychiatric hospital may tend to feel rather uneasy in the family circle. Despite the good will of all other members of the family, it is not unusual to find such a patient keeping to himself. If the visiting nurse knows in advance that a psychiatric patient is being discharged, she can visit the family before the patient returns home and help prepare them so that the adjustment process for everyone is speeded up.

Conclusion

It is evident that, for the public health nurse to provide services of this calibre, she has to have a good background of knowledge in psychology, psychiatry and sociology. She must know how to recognize normal behavior. She must understand the reactions of individuals to illness; to serious problems. She must be aware of the way in which some people will use their emotions, either to advantage or disadvantage, in reaching an adjustment. Understanding and accurate interpretation of the behavior of others

helps the nurse to meet their needs adequately. Her knowledge of applied psychology will make it possible for her to use special interviewing techniques. She, herself, must have emotional stability and be able to use her innate qualities of tact, objective observation, intuition, sympathy and understanding to best advantage. Development of these natural gifts will help her in making mental health an integral part of her daily work.

HYALINE MEMBRANE DISEASE

ELDA Y. DUNHAM

Hyaline membrane disease is the number one killer of premature infants.

OCCURRING IN 20 per cent of all premature births, hyaline membrane disease accounts for 40 per cent of the deaths in the neonatal period. Infants born by Caesarean section are also prone to the development of the disease, as well as those born of diabetic mothers and of mothers with obstetrical complications such as toxemia, placenta previa and accidental hemorrhage. It is seldom seen, however, in the full-term infant of a normal vaginal delivery.

One in a whole family of respiratory distress syndromes, this condition is characterized by a glassy, hyaline-type membrane that lines the alveolar ducts, blocking them off and thus preventing adequate exchange of gases between the alveoli and capillaries. Some vaguely-understood physiological disturbance produces, among other things, a chemical imbalance in the blood; because of this chemical imbalance and perhaps due to injury or immaturity of the capillaries, a high-protein fluid seeps through their walls into the surrounding lung tissue and alveoli. An earlier theory had the membrane formed from aspirated amniotic fluid and its contents — blood, vernix and meconium. Although there is a similar form of respiratory distress caused by these factors, it is now widely accepted that hyaline membrane disease is a distinctly separate condition.

Miss Dunham is presently engaged in tuberculosis survey work, in the province of Ontario with the National Sanitorium Association.

Clinical Picture

The infant usually breathes well and cries vigorously at birth; his color is often pink, air entry into the lungs is good, and the heart sounds are loud. Edema of the extremities may be present to a greater degree than in the average premature.

One-half to two hours after birth, the respirations may become rapid and labored with chest retraction. This retraction or indrawing may appear in the sternal, subcostal or intercostal regions, or the whole chest wall may be sucked inwards with each inspiration. Accompanying this is a moaning or grunting sound on expiration. These two symptoms — indrawing and grunting — indicate stiff lungs, probably caused by pulmonary edema as well as the forming membrane. Auscultation of the chest reveals a decreased air entry. A chest x-ray taken at this point shows a fine granular pattern distributed evenly throughout both lung fields.

The rate of progress of the symptoms depends upon the severity of the disease, but the general picture is one extending over some 40 to 60 hours. After the first 12 hours the symptoms may slowly subside — or they may progress. In the latter case, the respirations become more rapid, perhaps somewhat irregular, and extremely embarrassed, accompanied by flaring of the nostrils. Respiratory indrawing and grunting become markedly pronounced. The color may be pale or cyanotic though more often it remains remarkably pink until almost the height of the disease when there will be severe

cyanosis, a greyish pallor or a combination of both in the form of peripheral mottling. When disturbed, the child grimaces and emits an irritable whining cry. Otherwise, he lies limp and expressionless, as though the increased work of breathing utilizes every ounce of energy he has. Edema increases as excess proteins seep through the capillary walls into the surrounding tissues of the limbs, buttocks and face. Not only may râles be heard on auscultation of the chest, but also the heart sounds may be somewhat muffled. Again x-rayed, the lung will have changed appearance. Now, a uniform mottled pattern is present as small areas of the lobes are collapsed and become solidified. A secondary atelectasis has developed.

Poor Prognostic Signs

In this highly unpredictable disease the prognosis is guarded, but one always entertains a hope that an hour's time will show some improvement in the condition of the infant. However, there are several poor prognostic signs that must be watched for. When one or any combination of these signs — indicating exhaustion, heart failure, circulatory failure, or shock — present themselves, hope fades. They are: a sudden rise in the respiratory rate, a slowing heart rate, a drop in body temperature, cyanosis not relieved by oxygen, periods of apnea, the formation of sclerema, and unresponsiveness.

As the infant strives harder to meet his bodily needs for oxygen and rid himself of excess carbon dioxide, exhaustion overcomes him; he has a period of apnea with cyanosis. Spontaneously or with help he may rally, but these attacks continue; his respirations gradually become slower and more shallow and eventually he dies due to failure of blood-gas homeostasis. Twenty to 30 per cent of these infants die. Death occurs seldom before six hours, most frequently between six and 24 hours, and rarely after 60 hours.

Post-mortem examination reveals a severe pulmonary congestion, a secondary atelectasis, and the presence of a hyaline-type membrane lining the alveolar ducts.

Treatment and Nursing Care

One of the most important functions of the nurse is observation. Early recognition with prompt and accurate reporting of the signs are most helpful to the doctor in treating them. Another important nursing function is careful control of the infant's environment. The infant should be placed in an incubator that will maintain a definite temperature, humidity, and oxygen content without fluctuation. It is generally agreed that the incubator temperature should be regulated to maintain the infant's body temperature at 97°-98°. In order to do this the probable incubator temperature will be 85°-90°. However, in some centres it is felt that hypothermia may aid the infant's breathing by lowering his basal metabolism and decreasing his need for oxygen. The latter form of treatment is probably not as widely employed as is the former. In either case, the temperature should be checked every three to four hours and kept at the desired level.

A high humidity within the incubator is important for several reasons:

1. There is less body heat loss by evaporation in a humid atmosphere.
2. It helps to soften and loosen mucus and sticky secretions which may have collected in the air passages.
3. Humidity may help to keep the forming membrane pliable and penetrable by oxygen and carbon dioxide.

Respirations appear easier when an infant is moved from a dry to a moist environment. Supersaturation of the air is sometimes effected by means of a vaporizer. However, recent studies have found this to be of doubtful value to the infant. Oxygen may be given at low rates of flow, and if found to benefit the child in any way, it may be maintained at 35-40 per cent concentration. It should never be administered at a higher concentration unless indicated by cyanosis. An oxygen analyzer is always employed to measure the concentration every two to four hours.

Everything possible must be done to aid the breathing. The baby must not be hindered by clothing, positioning, or any obstruction in the nasopharynx. Great care must be taken to maintain the airway clear of mucus and fluid. Withdrawal of the stomach contents gives the assurance that regurgitation and aspiration into the lungs will not

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take place. Following this the infant may be placed in Trendelenberg position to aid in draining secretions from the lungs and air passages. This position may not be advisable for long, however, as the weight of the stomach contents thrown upward on the diaphragm could hamper the already-embarrassed efforts at respiration. On the other hand, should this position or any other position be found to aid the severe dyspnea, by all means keep him in that position as much as possible. By turning the child from side to side frequently and aspirating any secretions by means of gentle suction, the nurse is doing her utmost to maintain a clear airway and to provide and maintain good expansion of the lungs.

Changes in rate, rhythm, and depth of the respirations, as well as changes in color, activity and response must be noted carefully and reported promptly.

Drugs

There are several routine and emergency drugs that may be given in this disease. The first of these, given routinely, are antibiotics; these are administered in large doses as a prophylactic measure against secondary infections, the drugs of choice being chloromycetin and penicillin-streptomycin compounds. The second commonly used drug is digoxin, given to strengthen and stabilize the action of the heart. Some centres feel that it should be given as a matter of routine in severe cases, rather than only in those cases which have developed heart failure.

Emergency drugs such as caffeine and coramine are very little use in this condition. If apnea is not relieved by manual stimulation, caffeine can be employed. The usual 7½ grain ampoules are given at a dosage of one minim per pound of body weight up to a maximum of four minims. However, at this point, the time taken to prepare the injection would probably be better spent applying resuscitation by means of positive-negative pressure at a force no greater than 30 cubic centimeters of water.

Feeding

Since there is danger of regurgitation, vomiting and aspiration, there is a tendency to withhold oral feedings for periods up to 60 hours. Moreover, edema being present, there is also a contraindication to the use of hypodermoclysis. If, on the other hand, the infant becomes dehydrated before oral feedings are felt advisable, then hypodermoclysis could be employed. Early intravenous fluids are frequently administered as a means of balancing the blood chemistry in hope of arresting the progress of the disease.

Summary

Hyaline membrane disease causes 40 per cent of all premature neonatal deaths. It is a form of respiratory distress wherein a hyaline-type membrane lines and plugs the alveolar ducts and prevents adequate exchange of gases. As yet the exact cause of the disease is unknown but the offending membrane originates in a high-protein exudate from the capillaries. Onset takes place shortly after birth, the first symptoms being respiratory indrawing and grunting and perhaps edema of the limbs. Color may be cyanotic but more frequently it remains good until late in the progress of the disease. As the symptoms become more severe, keen observation will reveal signs of exhaustion, heart failure, circulatory failure and shock. Death occurs in 20 to 30 per cent of those affected, usually between six and 48 hours of life. Diagnosis is made by x-ray which reveals a typical, uniform, granular pattern followed by a mottled appearance and finally by solidification of the entire lung; this last of course is found on post-mortem. Treatment includes careful observation by experienced persons, warmth, humidity, and oxygen as well as the administration of prophylactic antibiotics. As yet there is no known specific life-saving treatment available for these infants, although much research is presently being carried out. The only known prevention is normal vaginal delivery at term.

Absence of occupation is not rest,
A mind quite vacant is a mind distress'd.
— COWPER

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Is a little lost pup with his tail tucked in!
— ARTHUR GUITERMAN

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In Memoriam

Margaret Helen (Murray) Cameron who graduated from the Vancouver General Hospital in 1916, died early this year in California.

* * *

Frances A. Graham, a nurse in the Spanish-American war of 1898, died in Vancouver early this year. She was 94 years of age.

* * *

Irene LeBel, a graduate of Hôpital de la Miséricorde, Montreal in 1934, died on April 4, 1960. For 23 years she gave outstanding service in outpost areas of the province of Quebec.

* * *

Katharine Margaret MacMillan, a nursing sister in World War I, died in Vancouver on April 3, 1960.

* * *

Audrey V. McClymont who was a head nurse at the Woodlands School for retarded children in New Westminster, B.C. died in a highway accident April 17, 1960.

* * *

Rosaline Maillet, a graduate of Hotel Dieu Hospital, Moncton, died in a car accident on April 17, 1960. She had been engaged in public health nursing in New Brunswick.

* * *

Amy (Pollard) Morford, an 1891 graduate of the Mack Training School for Nurses, St. Catharines, Ont. died in New York City on March 5, 1960. Prior to her marriage she organized the first school for nurses in St. Thomas, Ont. She maintained an active interest in her own school throughout the years and was able to be present for its 75th anniversary in 1949.

* * *

Glory B. Morrison who graduated from the King Edward Memorial Hospital, Hamilton, Bermuda in 1923 died in Toronto on March 16, 1960. During her professional career she had nursed in Bermuda, Newmarket, Ont., Toronto, Vancouver and New York.

* * *

Gwen Nash, a graduate of the University College Hospital, London, England in 1950 died in a car accident near Sydney, N.S. on April 17, 1960. She had been engaged in public health nursing in New Brunswick.

* * *

Myrtle (Lawson) Sansone who graduated from St. Joseph's Hospital, London, Ont. in 1923 died on March 17, 1960. For several years she was on the staff of Ford Hospital, Detroit.

* * *

Doreen (Clifford) Saunders, a 1952 graduate of Ottawa Civic Hospital died suddenly on February 23, 1960. She had been on the staff of the hospital until her marriage.

* * *

Edith Tye, who graduated from The Amasa Wood Hospital, St. Thomas, Ont. in 1904 died in December, 1959. She had been active in her profession for over 50 years.

* * *

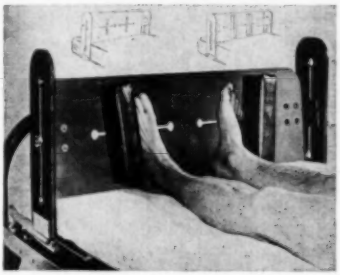
Ivy M. Weston who graduated from the Grey Nuns' Hospital, Regina in 1922, died on April 29, 1960. She had been engaged in nursing in New York City.

Adults want to discern some relevance in what they study. They do not easily submit to shabby, threadbare lectures. The adult wants to participate, to try out ideas, to test hypotheses, to judge and dissent. He is not anxious to memorize some code of truth. He feels with Sam Slick; "You may stop a man's mouth by crammin' a book down his throat, but you won't convince him." What he wants most are experiences to be tasted and tested. There is a place for honest difference of opinion, for the free and fair engagement in controversy, and it is to be hoped that . . . ample provision will be made for it. — Dr. J. Roby Kidd

A special committee of the Nursing Education Alumnae Association of Teachers College, Columbia University, is taking steps to establish an endowed research professorship in nursing and nursing education. The professorship will be in honor of the contribution of Miss **Isobel Maitland Stewart,** Professor Emeritus of Nursing Education at T.C. The proposed professorship will be the first to honor a living T.C. professor and will make possible continuing research in nursing and nursing education. *T.C. Topics,* Spring, 1960

* * *

Those who cannot remember the past are condemned to repeat it. — Santayana



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Book Reviews

Mayes' Handbook for Midwives and Maternity Nurses. Revised by F. D. Thomas, S.R.N., S.C.M. 476 pages. The Macmillan Company of Canada Limited, 70 Bond St., Toronto. 6th ed. 1959. Price $3.85.

Reviewed by Mrs. T. Beveridge, Box 9600, Selkirk, Manitoba.

This text requires little introduction to Canadian nurses. Although primarily directed towards candidates for certification by the British Central Midwives Board, it has achieved a place on the bookshelf of the well-read nurse in this country.

This recently revised edition lives up fully to the expectations of those who are familiar with earlier versions. In addition to being more up-to-date, the subject matter has been expanded and streamlined to include a comprehensive coverage of both normal and abnormal obstetrics, analgesia in childbirth, relaxation and exercises, abnormalities of the infant, and a short history of midwifery.

The chapters on domiciliary midwifery and Government services, while interesting, are superfluous for the Canadian nurse.

A particularly pleasing feature is the inclusion, at the end of each chapter, of a short list of questions. They serve to emphasize important points discussed as well as affording an excellent means of review.

This book is highly recommended to Canadian nurses, particularly those who intend to specialize in the field of obstetrics, as it combines accuracy with a superb clarity of presentation, both in text and in illustration.

Nursing of Children by Robert A. Lyon, M.D. and Elgie M. Wallinger, R.N., B.S., M.A. 554 pages. W. B. Saunders Company, West Washington Square, Philadelphia. 5th ed. 1959. Price $5.00.

Reviewed by Mrs. A. Game, Clinical Instructor, The Children's Hospital, Winnipeg.

The present revision has taken into account the general trend toward emphasizing that a knowledge of normal growth and development and of nutritional patterns is essential when caring for children. Upon this basic foundation the care of the sick child has been built.

The material has been expressed clearly and has been arranged in six units. The first two discuss the normal growth and development and nutritional requirements of the healthy child. Unit three is a new addition and deals with the well child. Units four and five are devoted to the child in hospital and to childhood diseases — diagnosis, treatment, nursing care and prevention. The last unit describes the institutions and organizations outside of the hospital

which offer services to special groups of children.

The text is well illustrated. Headings and sub-headings provide easy identification of subject material. Reference lists at the end of each unit are adequate and up-to-date. Throughout the book there is a constant reminder for the nurse that she is replacing "the parent in supplying security and love which the child needs for a rapid and complete recovery."

This text should be an excellent reference for student nurse and of great value to the instructor.

Surgery for Nurses by James Moroney, M.B., Ch.B., F.R.C.S. (Eng.), L.R.C.P. (Lond.). 751 pages. The Macmillan Company of Canada Limited, 70 Bond Street, Toronto. 6th ed. 1959. Price $5.00.

Reviewed by Miss Marie Swarychewski, St. Rita Hospital, Sydney, N.S.

The illustrations in the book are exceptionally good, the subject material is well presented. Explanations are brief and very clear. The many "whys" are answered adequately in each chapter. As with all texts there may be some differences of opinion regarding techniques and procedures. I would strongly recommend this book as a good surgical nursing reference.

Obstetric and Gynecologic Milestones by Harold Speert, M.D. 700 pages. Brett-Macmillan Ltd., 132 Water St. S., Galt, Ont. 1958. Price $15.00.

Reviewed by Miss Gertrude Yeats, Kingston, Ontario.

This book gives a concise picture of the great men in medical history and deals particularly with the development of obstetrics and gynecology. Eponymic nomenclature, long familiar to us but often not fully understood as to its origin, comes to life as the author relates the stories of the men whose names have become inseparably linked with equipment, procedures and so forth, for example Piper forceps, Braxton Hicks sign.

Instructors will find excellent resource material for teaching anatomy, obstetrics, gynecology and history of nursing.

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Matron for 31-bed hospital. Must have or be eligible for B.C. registration. Salary $360 per mo., full board & 3-room suite $33, 1-mo. vacation after 1-yr. Applications to: Administrator, General Hospital, Ocean Falls, British Columbia.

Registred Nurses for new 250-bed accredited hospital, General Duty all departments. Salary $270, $285 - $342. 1-mo. vacation plus 10 statutory holidays after 1-year. 50% medical coverage. Implementation of superannuation expected this year. 6-mi from the centre of Vancouver city. Write or wire: Director of Nursing, General Hospital, Burnaby, British Columbia.

Registered Nurse for new 26-bed hospital in the Fraser Canyon 100-mi. east of Vancouver, B.C. Basic salary $285 — shift differential, 40-hr. wk., 1-mo. annual vacation. Accommodation available in a new nurses' residence. Apply: Director of Nurses, Fraser Canyon Hospital, **Hope,** British Columbia.

General Duty Nurses for small active hospital. Salary $270 for unregistered, $285 registered with yearly increments. Nurses' home available. For further particulars write, The Administrator, Lady Minto Hospital, Ashcroft, British Columbia

General Duty Nurses for 200-bed General Hospital with School of Nursing. Salary $275-$327. Pre-planned shift rotation, B.C. registration essential. 4-wk. vacation after 1-yr. Apply: Director of Nursing, Royal Inland Hospital, Kamloops, British Columbia.

O.R. Supervisor, P. G. preferred (1), **General Duty Nurses** (2) Starting salary $285, personnel policies in accordance with R.N.A.B.C. recommendations. Health plan in operation, retirement plan effective July 1, 1960. Comfortable nurses' residence, full maintenance $55. Situated 80-mi. upcoast from Vancouver with daily bus & plane connections. Apply to: The Director of Nursing, General Hospital, Powell River, British Columbia.

General Duty Nurses for 110-bed hospital in B.C.'s Northwest. Salary $299 per mo., if experienced; $285 - $342 in 4-yr. Modern residence facilities available. Supervisory positions also available, $330 - $400 per mo. For complete information apply to: The Director of Nursing, General Hospital, Prince Rupert, British Columbia.

General Duty Nurse for well-equipped 80-bed General Hospital. Initial salary $285, maintenance $47.50. 40-hr. 5-day wk., 4-wk. vacation with pay. Apply: Sacred Heart Hospital, Smithers, British Columbia.

General Duty Nurses for modern 154-bed General Hospital Basic salary $285, generous personnel policies, nurses' residence. Apply to: Director of Nurses, Trail-Tadanac Hospital, Trail, British Columbia.

General Duty Nurses: starting salary $299 if 2 yr. experience, $285-$342 in 4 yr. Non registered $270 Maintenance $50, 10 statutory holidays, 4-wk. annual vacation. 1½ day sick leave per mo. very active town, world famous Cariboo cattle country, annual stampede. Apply: Director of Nursing, War Memorial Hospital, Williams Lake, British Columbia.

General Duty & Operating Room Nurses for 434-bed hospital with training school; 40-hr. wk., statutory holidays. Salary $285-$342. Credit for past experience & postgraduate preparation; annual increments; cumulative sick leave; 28-days annual vacation. B.C. registration required. Apply: Director of Nursing, Royal Columbian Hospital, New Westminster, British Columbia.

Obstetric, Operating Room & General Duty Nurses (Immediately) for new modern 125-bed hospital in central B.C., surrounded by magnificent scenery & excellent sporting opportunities. Starting salary B.C.R.N. $285 plus $14 increment with 2-yr. experience. Modern nurses' residence available. Apply: Nursing Supervisor, Regional Hospital, Prince George, British Columbia.

Male Operating Room Nurses (Registered in British Columbia) ability to carry responsibilities of a circulating nurse essential. Experience preferred. Salary $285-$342; differential for postgraduate work. 40-hr. wk., rotating shifts, no "call" work; 4-wk. annual vacation, cumulative sick time, health plan. Apply to: Director of Nursing, Royal Columbian Hospital, New Westminster, British Columbia.

Graduate Nurse for 31-bed hospital, salary $275 per mo., **B.C. Registered Nurses** $285, with 4 annual increments of $14, 40-hr. wk., 4-wk. vacation, 1½-days sick leave per mo., Lodging $11 per mo. Fare from Vancouver refunded after 6-mo. For personnel policies & information apply to: Administrator, General Hospital, Ocean Falls, British Columbia.

Graduate Nurses for 70-bed acute General Hospital on Pacific Coast. Starting salary $275 with regular increases. Board & room $25 per mo., 5-day wk., 28 days vacation plus 10 statutory holidays. Apply: Matron, St. George's Hospital, Alert Bay, British Columbia.

Graduate Nurses (2). Salary: $285 per mo. Room, board & laundry: $40 per mo. 28-day vacation after 1-yr. service. All statutory holidays paid. Customary sick leave. Apply: Matron, Slocan Community Hospital, New Denver, British Columbia.

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Sarnia is a rapidly growing city located midway on the seaway, 60 miles north of Detroit and Windsor and 60 miles west of London. It is a summer resort area noted for swimming and boating as well as being located a reasonable distance from the skiing resorts in Northern Michigan.

Excellent benefits include a 40 hour week, regular rotation of shifts with premium pay for evenings and nights.

Salary Schedule:

for Registered Nurses — $265 per month to $324 per month.

for Certified Nursing Assistants — $182 per month to $215 per month.

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Registered Nurse (1-Immediately) for 11-bed hospital. Salary $310 per mo. with increments, less $45 per mo. full maintenance, living quarters in hospital. Apply to: Birch River Hospital Unit, Birch River, Manitoba.

Registered Nurse for 10-bed rural hospital, starting salary $300 per mo., with semi-annual increments. Other valuable benefits. Opportunity of becoming Matron if interested. Apply: Secretary-Treasurer, Box 235, Fisher Branch, Manitoba.

Registered Nurses for 8-bed hospital. Gross salary $310 per mo., full maintenance provided at $45 per mo. Apply: Superintendent, Medical Nursing Unit, Notre Dame de Lourdes, Manitoba.

Registered Nurses (2) for 20-bed hospital. Salary: $300 per mo. gross. 40-hr. wk. with 4 annual increments of $10. 3-wk. vacation with pay after 1 full yr. employment, 4-wk. after 2 full years. Sick leave, 1 day for each full mo. of employment plus 1 day for each full 6-mo. employment cumulative to 30 days. Apply: Matron or A.C. Laughlin, Secretary, Wilson Memorial Hospital, Melita, Manitoba.

Registered or Licensed Practical Nurse for General Duty for hospital now rated at 8-beds will be increased to 16 when new construction is completed. Gross salary $325 for R.N., $220 L.P. less $45 for full maintenance, 40-hr. wk. with sick leave benefits. Attractive new nurses' residence. For further particulars apply to: John Hiscock, Secretary-Treasurer, Box 225, Baldur, Manitoba.

Registered & Licensed Practical Nurses. Salary rating for Registered Nurses, min. $275 - max. $304 per mo. with $10 additional for evening duty; for Licensed Practical Nurses min. $208 - max. $230 per mo. 8-hr. duty (day, evening or night), 40-hr. wk. Must be registered or licensed in Manitoba. Apply in writing to: The Director of Nursing, Municipal Hospitals, Winnipeg 13, Manitoba.

General Duty Registered Nurses & Registered Nurses for Supervisory duties at Selkirk General Hospital, Selkirk, Manitoba. New, Well-equipped hospital, close to Winnipeg, hourly bus schedule. Salary in keeping with Manitoba schedules. Apply: P.O. Box 5000, Selkirk, Manitoba.

General Duty Nurses (3) for new 85-bed hospital. Good salary & generous personnel policies. Apply: Director of Nursing, Portage Hospital District #18, Portage La Prairie, Manitoba.

NEW BRUNSWICK

Assistant Head Nurse for psychiatric division. Apply stating qualifications & experience to: Director of Nursing, Saint John General Hospital, Saint John, New Brunswick.

Registered Nurses (Immediately) for modern 25-bed hospital. Starting salary $240 per mo. with bi-annual increases. Room & board in modern residence $40 per mo. For further information write: Miss M. Giberson, Superintendent, Tobique Valley Hospital, Plaster Rock, New Brunswick.

NORTH WEST TERRITORIES

General Duty Nurses (2) for 44-bed hospital in progressive northern gold mining town. Salary $294 with $10 increments yearly for 3-yrs., maintenance $25, 1-mo. annual vacation. Transportation, Edmonton-Yellowknife plus freight on 100 lbs. of baggage provided. Apply: Director of Nursing, District Hospital, Yellowknife, North West Territories.

NOVA SCOTIA

Supervisor (Floor) & Assistant Superintendent for small modern General Hospital situated on the beautiful south shore of Nova Scotia. Starting salary $280 gross, $40 deduction for board. Pension plan pending. Course in Supervision preferred. Must have had Supervisory experience. **Also O. R. Nurse** required. Starting salary $250. Apply: Superintendent, Fisherman's Memorial Hospital, Lunenburg, Nova Scotia.

Registered Nurses for Floor Duty (Immediately) 40-hr. wk. Nova Scotia R.N.A. salary scale. Apply to: Superintendent of Nursing, Western Kings Memorial Hospital, Berwick, Nova Scotia.

General Duty Nurses (Immediately). Good personnel policies. Apply: Superintendent, Queens General Hospital, Liverpool, Nova Scotia.

General Duty Nurses for modern 35-bed hospital situated on beautiful South Shore. Good personnel policies. Excellent living quarters. Apply Superintendent, Fishermen's Memorial Hospital, Lunenburg, Nova Scotia.

Director of Nursing Service for modern 100-bed hospital, day duty only, salary open, excellent personnel policies. Interview will be arranged. Forward enquiries to: Director of Nursing, St. Vincent de Paul Hospital, Brockville, Ontario.

Floor Supervisor & General Duty Nurses for 50-bed hospital, 40-hr. wk., 8 statutory holidays, comfortable residence. Meaford is situated on Georgian Bay & is a tourist town. For further information apply to: Director of Nurses, General Hospital, Meaford, Ontario.

Clinical (Teaching) Supervisor for Operating Room: postgraduate study essential; previous teaching experience desirable; duties to include staff orientation & in-service education; an interesting position for a progressive person; attractive personnel policies; salary in accordance with preparation & experience. Apply: Director of Nursing, The Doctors Hospital, 45 Brunswick Avenue, Toronto 4, Ontario.

Medical-surgical Clinical Teacher (1). Apply: Director of Nursing, Hotel Dieu Hospital, Kingston, Ontario.

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Requires staff for the following positions:

Assistant Supervisor Operating Room —

Postgraduate study in operating room supervision and management.

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Excellent salary and personnel policies

Additional salary paid for postgraduate study in specialty.

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Requires

General Staff Nurses for Medical, Surgical, Obstetrical and Pediatric Services. Forty hour week. Salary $270 to $310 gross per month. Differential for evening and night duty. Residence accommodation if desired.

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New school building, new student residence. Hospital opened in 1956, all services; 250-beds.

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Opportunities for additional education at Laurentian University.

Salary according to qualifications and experience.

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DIRECTOR OF NURSING, SUDBURY MEMORIAL HOSPITAL,
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Modern hospital 42-adult beds, 11-bassinets, located in a company operated town & serves a population of approximately 6,000. Salary range from $357 - $477 per mo., commensurate with experience & qualifications. Community organized recreation, residence accommodation & all conventional benefits available.

Apply giving full particulars of training & experience to:

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IROQUOIS FALLS, ONTARIO.

Supervisor of Public Health Nursing required by Peel County Health Unit, a rural-urban area with a population of 100,000 near Toronto. Applications are invited from qualified nurses for this appointment. Present staff 20-nurses. For details write: Dr. D. G. H. MacDonald, Medical Officer of Health, 44 Nelson Street West, Brampton, Ontario.

Female Superintendent for 30-bed modern hospital, located in the Town of Matheson — Staff 28. To be responsible for Supervision of Staff; and all phases of hospital operation — (except accounting). Separate suite of rooms for Superintendent — beautiful location. Duties to commence May 1, 1960. Please apply, stating age, qualifications & salary expected, to M. D. Kaye, Chairman of Board of Directors, Bingham Memorial Hospital, Matheson, Ontario. — Phone 375.

Assistant Superintendent, Registered Nurse for 73-bed General Hospital. Salary depending upon experience & qualifications. Residence accommodation available. Apply to: Superintendent, General Hospital, Kenora, Ontario.

Clinical Instructor for the Plummer Memorial Public Hospital School of Nursing. Address applications to: The Administrator, Plummer Memorial Public Hospital, Sault Ste. Marie, Ontario.

Instructors for Medical-Surgical Nursing, & Nursing Arts, in school of nursing, with new facilities opened this year. Apply to: Director of Nursing, General Hospital, Belleville, Ontario.

Head Nurse for Newborn Nursery in modern department; postgraduate experience desirable, but previous experience would be considered. Attractive personnel policies. Salary in accordance with qualifications. Apply: Director of Nursing, The Doctors Hospital, 45 Brunswick Avenue, Toronto 4, Ontario.

Registered Nurses for expanding General Hospital, Medical, Surgical, Operating Room & Obstetrical services, at Ajax on Highway 401, 20-mi. east of Toronto, hourly bus service to hospital. R.N.A.O. salary schedule, increments every 6-mo., sick & vacation time after 6-mo., 37½-hr. work wk., pension plan, living in accommodation. Apply to: Director of Nursing, Ajax & Pickering General Hospital, Ajax, Ontario. **Nurses from Europe & United Kingdom,** apply to: Canadian Department of Labor, 61 Green Street, London, W.1, England.

Registered Nurses & Certified Nursing Assistants for immediate & future vacancies in modern 42-bed hospital. Starting salary $265 & $180 respectively, plus shift allowances. Excellent personnel policies. Apply: Superintendent of Nurses, New Liskeard & District Hospital, New Liskeard, Ontario.

Registered Nurses & Certified Nursing Assistants for 160-bed hospital. Starting salary $265 & $185 respectively with regular annual increments for both. Excellent personnel policies including 5-day wk. & residence accommodation available. Assistance with transportation can be arranged. Apply: Superintendent, Kirkland & District Hospital Kirkland Lake, Ontario.

Registered Nurses & Certified Nursing Assistants for well equipped 60-bed hospital in small, friendly community on main line of C.P.R. Liberal personnel policies with salaries above R.N.A.O. recommendations. Attractive living accommodation available. Apply: Director of Nursing, Lady Minto Hospital, Chapleau, Ontario.

Registered Nurses ($255 - $285) & **Certified Nursing Assistants** ($185 - $215) for modern 90-bed General Hospital in attractive town near Toronto & resort areas. Annual increments, accumulative sick leave, pension plan, shift differential, 40-hr. wk. Apply to: Director of Nursing, Dufferin Area Hospital, Orangeville, Ontario.

Registered Nurses for General Duty in modern 58-bed hospital, North-Western Ontario tourist area town, midway Fort William & Winnipeg. Gross salary $285 per mo. with increments & consideration for past experience. Excellent personnel policies, pleasant working conditions. Single room residence accommodation. Apply: Director of Nursing, Dryden District General Hospital, Dryden, Ontario.

Registered Nurses for General Duty in all departments including premature & newborn nursery, Isolation, Emergency & Recovery Room. Good salary & personnel policies. Apply, Director of Nursing, Victoria Hospital, London, Ontario.

Registered Nurses for General Duty in modern 18-bed. Private Hospital in iron mining town. 180-mi. north of Sault Ste Marie, Ontario. Excellent accommodation & personnel policies. Starting salary $268 minimum to $303 maximum for experience, less $20 per mo. maintenance. Transportation allowance after 6-mo. service. **Operating Room Nurse,** starting salary $288 minimum with postgraduate course, $323 maximum with 3-yr. experience or more. Apply: Superintendent, Miss O. Keswick, Lady Dunn Hospital, Wawa, Ontario.

Registered Nurses for General Duty on Surgical Floor in 163-bed Sanatorium. Good salary & personnel policies. Residence accommodation available. Apply: Director of Nurses, Sudbury & Algoma Sanatorium, P.O. Box 40, Sudbury, Ontario.

Registered Nurses for General Staff & Operating Room in modern hospital (opened in 1956). Situated in the Nickel Capital of the world, pop. 50,000. **Salary: $270 per mo.** with annual merit increments, **plus annual bonus plan,** 40-hr. wk. Recognition for experience. Good personnel policies. Assistance with transportation can be arranged. Apply Director of Nursing, Memorial Hospital, **Sudbury,** Ontario.

General Duty Nurses for new 35-bed active hospital. Salary $250 for Registered. Full particulars. Apply: Superintendent, Uxbridge Hospital, Uxbridge, Ontario.

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Here's an opportunity to gain unique and valuable experience in a *public* hospital — world's largest for acute medical conditions. Cook County Hospital offers you the stimulation of working with more than 2,500 other doctors and nurses in one of the world's largest and most exciting medical centers. Housing is available at nominal cost. Salaries begin at $345-$385 for a 37½ hour week. And you're only minutes from Chicago's fabulous Loop and local universities.

Graduate Nurses! Write today to Director, Cook County School of Nursing, Dept. C., 1900 West Polk Street, Chicago 12, Illinois.

Registered Nurses for Staff Duty & Operating Rooms in General Hospital. Modern wings increasing to 64-beds to be opened this summer. Good salary & personnel policies. Apply to: Director of Nursing, Arnprior & District Memorial Hospital, Arnprior, Ontario.

Registered Nurses or Graduate Nurses for General Duty in modern 100-bed hospital. Basic salary $250 for R.N. 40-hr. wk. good personnel policies. Apply: Superintendent of Nurses, Smiths Falls Public Hospital, Smiths Falls, Ontario.

Registered General Duty Nurses (Immediately) for 29-bed hospital. Salary: $265 per mo. with increments up to $295. 4-wk. vacation with pay after 1-yr. service. 8 statutory holidays. Nicely furnished nurses' residence. Apply: Superintendent, Bingham Memorial Hospital, Matheson, Ontario.

Registered General Duty Nurses (all departments) in new 300-bed hospital in Niagara Peninsula. Starting salary $270 with 3-annual increments to $300 per mo., 40-hr. 5-day wk., with 3-wk. annual vacation, residence accommodation available. Apply to: Director of Nursing, County General Hospital, Welland, Ontario.

Registered Staff Nurses for all departments (including Operating-Room); 5-day wk; 8 statutory holidays; 3-wk. vacation annually; starting salary $270 per mo., 3 annual increments; rotating hours of duty. For further information apply to: Director of Nursing, The Doctors Hospital, 45 Brunswick Avenue, Toronto, Ontario.

Registered General Staff Nurses for all services, R.N.A.O. salary schedule, increments every 6-mo. 40-hr. wk., differential for evening & night duty. Excellent personnel policies & pension plan. Apply to the: Director of Nursing, St. Vincent de Paul Hospital, Brockville, Ontario.

General Duty Registered Nurses & Certified Nursing Assistants for 73-bed General Hospital on Lake of the Woods. Starting salary for nurses currently registered in Ontario $275-$305 for Nursing Assistants holding Ontario certificate $190-$220, full maintenance $50 monthly. Apply to: Superintendent, General Hospital, Kenora, Ontario.

General Duty Nurses (Immediately) for 30-bed hospital. Reply stating experience & salary expected. Reply to: Secretary, Englehart & District Hospital Board, Englehart, Ontario.

General Duty Nurses for an accredited 64-bed hospital. Starting salary: $265-$295, Excellent personnel policies, pension plan, residence accommodation. Apply Director of Nursing, Douglas Memorial Hospital, Fort Erie, Ontario.

General Duty Nurses for modern 100-bed hospital with building program just completed. Registered start at $260 monthly, Graduates at $225; 40-hr. wk., benefits include accident, sickness & life insurance, hospital & medical insurance plans, & O.H.A. Pension Plan. Opportunities for O.R. work. Busy hospital located near Point Pelee National Park, short drive from Detroit, Michigan. Apply: Miss Tillett, Director of Nursing, Leamington District Memorial Hospital, Leamington, Ontario.

General Duty Nurses for 100-bed hospital, up-to-date facilities in a beautiful location on the shore of Lake Erie. Salary $267 per mo. with recognition for P.G. courses, 40-hr. wk. effective January 1, 1960. Residence available, Apply: Director of Nursing, General Hospital, Port Colborne, Ontario.

General Duty Nurses for 100-bed modern hospital, south-western Ontario, 32-mi. from London. Salary commensurate with experience & ability; basic: $265, max.: $295. Residence accommodation available. Pension plan. Apply giving full particulars to: The Director of Nurses, District Memorial Hospital, Tillsonburg, Ontario.

Public Health Nurses qualified for generalized program. Minimum salary $3,500 with annual increments & allowance made for experienced nurses. Apply to: Supervisor of Nursing, **Fort William & District Health Unit,** 900 Arthur Street, Fort William, Ontario.

General Duty Nurses Male & Female & Certified Nursing Assistants (Immediately) for 86-bed hospital, 40-hr. wk., 8 statutory holidays & other employee benefits. Collingwood is situated on Georgian Bay & is noted as a vacationland with 7-mi. sand beach along with great skiing on the Blue Mountains in winter. For further information apply: Director of Nursing Services, General & Marine Hospital, Collingwood, Ontario.

General Duty Nurse & Certified Nursing Assistants for 100-bed General Hospital attractive town in vacation resort area on Lake Huron. Good personnel policies, residence accommodation available. Apply to: Director of Nursing, Alexandra Marine & General Hospital, Goderich, Ontario.

McKellar General Hospital, Fort William, Ontario has openings in all departments for **General Staff Nurses.** Basic salary $270 per mo., 40-hr. wk. Good personnel policies for other benefits. Residence accommodation available. Apply to: The Director of Nursing.

Public Health Nurses (qualified). Generalized program includes some bedside nursing. Salary $3,200-$4,250, annual increment $150, 5-day wk., car provided or car allowance. Apply to: Dr. Charlotte M. Horner, Director, Northumberland-Durham Health Unit, Cobourg, Ontario.

Public Health Nurses (qualified) for generalized program in Etobicoke Township (suburb of Toronto). Minimum salary $3,750; starting salary based on experience. Car allowance $670 per annum. 4-wk. vacation after 1-yr., pension plan, P.S.I. & Blue Cross benefits. Apply: Director of Public Health Nursing, Township of Etobicoke, 550 Burnhamthorpe Road, Etobicoke, Ontario.

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Opportunities for men & women on the service of your choice. A 953-bed teaching hospital with a friendly atmosphere, well planned orientation program, active graduate nurse club, cultural advantages & excellent transportation facilities.

Starting salary: $325 per mo., 6 holidays, sick leave, 3 wk. vacation.

For further details write:

Director — Nursing Service, University Hospitals of Cleveland, Ohio.

DIRECTOR OF NURSING

General Hospital of 109 beds, located in Northwestern B.C.
requires Director of Nursing.
Salary is open and dependent on qualifications and experience.
Residence accommodation available if desired.

Apply giving full particulars of education and experience to:
ADMINISTRATOR, PRINCE RUPERT GENERAL HOSPITAL, PRINCE RUPERT, B.C.

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For further information write to:
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Certificate in Nursing Education required - One to teach basic Science - Student enrollment 70-80 - One class per year, registers in September - Well equipped modern School & Residence

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Previous supervisory experience required. Certificate in Nursing Service Administration desirable.

200-bed hospital - fully accredited. Pleasant city 38,000 close to larger centres. Good salary & personnel policies. Additional salary for advanced preparation above positions. *For further details apply to:*

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Public Health Nurses for generalized program with City of Chatham, minimum salary $3,500 — 5-day wk., annual increments, 4-wk. vacation, pension plan, Windsor medical & hospitalization plan, car allowance (monthly) & sick leave, consideration given for experience. Apply to: Miss M. Mackenzie, Supervisor of Nurses, P.O. Box 787, Chatham, Ont.

Public Health Nurse for generalized program. Salary $3,500 - $4,375 over a 5 year period, pension plan, P.S.I. Apply: Mr. D. T. McLeod, Secretary-Treasurer, District of Kenora Health Unit, Box 174, Kenora, Ontario.

Public Health Nurses (Qualified) required in a generalized program in rural & semi-urban area adjacent to metropolitan Toronto. Excellent working conditions including pension plan, group insurance & transportation arrangements. Write: Dr. R. M. King, York County Health Unit, Newmarket, Ontario.

Public Health Nurses qualified for a generalized program in the City of Oshawa. Salary range $3,500 - $4,370; annual increment $175; starting salary based on experience. 5-day wk., 4-wk. vacation, pension plan, group insurance, hospitalization & P.S.I. employer shared. Transportation provided. Apply: Dr. C. C. Stewart, Medical Officer of Health, 50 Centre Street, City Hall, City of Oshawa, Oshawa, Ontario.

Public Health Nurse for September 1960 (Preston Board of Health). For further information write: Mrs. Bertha M. Young, Health Centre, 566 Duke Street, Preston, Ontario.

Public Health Nurses for generalized nursing program. Salary range $3,500-$4,400, annual increment $150, salary based on experience. 5-day wk., vacation 4-wks., pension plan & P.S.I. available. Car allowance or transportation provided. Apply to: Director, St. Catharines-Lincoln Health Unit, St. Catharines, Ontario.

Public Health Nurses for generalized Public Health Nursing Service, hospital plan, hospital P.S.I., pension plan, sick leave accumulative at the rate of 1½-days monthly, vacation 4-wks. a year, allowance for use of own car. Salary ceiling at present $4,300, initial salary dependent on experience. Apply to: Dr. J. R. Mayers, M.O.H & Director, Norfolk County Health Unit, 58 Peel Street, Simcoe, Ontario.

Public Health Nurses for generalized public health nursing service; maternal & child health, tuberculosis, school health etc. Salary $3,500-$4,500 annually; annual increment $200. Hospital plan, P.S.I., pension plan, sick leave - 1½ days monthly, accumulative. Vacation - 4-wk. yearly. Transportation provided or allowance for use of private car. Uniform allowance - Initial $200, yearly $75. Apply to: Dr. J. B. Cook, M.O.H. & Director, Sudbury & District Health Unit, Sudbury, Ontario.

Public Health Nurses (2) Bilingual for generalized public health nursing service; maternal & child health, tuberculosis, school health etc. Salary $3,500 - $4,500 annually; annual increment $200. Hospital plan, P.S.I., pension plan, sick leave- 1½-days monthly, accumulative. Vacation - 4-wk. yearly. Transportation provided or allowance for use of private car. Apply to: Dr. J. B. Cook, M.O.H. & Director, Sudbury & District Health Unit, Sudbury, Ontario.

Public Health Nurses (Qualified) for Victorian Order of Nurses (Toronto Branch). Minimum salary $3,600, consideration given to past experience. Annual increments, 5-day wk., 4-wk. vacation. $100 uniform allowance. P.S.I. & Supplementary Blue Cross available, pension plan benefits. Apply: Director, 281 Sherbourne Street, Toronto 2, Ontario. WA. 1-3184

Public Health Nurses for Staff positions. Starting salary $3,600 with uniform allowance & annual increments. Good personnel policies. Apply to: Miss Helen Saunders, Director, Victorian Order of Nurses, Windsor, Ontario.

Operating Room Nurses for general operating room work which includes cardiovascular, neurosurgery, genito-urinary, Ear, Eye, Nose & Throat & orthopedic surgery. Good salary & personnel policies. Apply: Director of Nursing, Victoria Hospital, London, Ontario.

Nurses (Bilingual) having a public health certificate for a Health Unit in rural Ontario. Minimum salary $3,300, 5-day wk., cars available or allowance for own car. Cumulative sick leave. For further information write to: Dr. R. G. Grenon, Director, Prescott & Russell Health Unit, Hawkesbury, Ontario.

Registered Nurse to take charge of new operating room — also **General Duty Nurses** for modern 55-bed hospital, situated in Bruce County, town of 3,000 people, on the shores of Lake Huron. Accommodation available in nurses' residence. Excellent recreational facilities, & all churches represented. Apply to: Superintendent, General Hospital, Kincardine, Ontario.

Operating Room Supervisor for 250-bed hospital. Postgraduate study required. Good salary & personnel policies. Apply: Director of Nursing, Grace Hospital, Windsor, Ontario.

BERMUDA

Registered Nurses for Operating Room with operating room postgraduate course and/or experience, for 140-bed hospital. Travel allowance paid. For particulars, write Matron, King Edward VII Memorial Hospital, Bermuda.

QUEBEC

Matron (preferably bilingual) for July for newly constructed modern 23-bed General Hospital located at Murdochville. Duties to include supervision of personnel & general hospital maintenance. Excellent recreation facilities including indoor swimming & artificial ice. Three (3) churches. Reply stating age, experience & training to Box No. L, The Canadian Nurse Journal, 1522 Sherbrooke Street West, Montreal 25, Quebec.

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(4) Hospital Staff Nurses: up to $3,750 per year depending upon qualifications and location.

(5) Certified Nursing Assistants or Licensed Practical Nurses: up to $200 per month depending upon qualifications and location.

• Room, Board and Laundry in residence at reasonable rates. Statutory holidays. Three week's annual leave with pay. Generous sick leave credits. Hospital-Medical and superannuation plans available.

• Special pay and leave allowances for those posted to isolated areas.

For interesting challenging, satisfying work apply to — Indian and Northern Health Services at one of the following addresses:

(1) Regional Superintendent, 4824 Fraser Street, Vancouver, B.C.

(2) Regional Superintendent, 11412-128th Street, Edmonton, Alberta.

(3) Regional Superintendent, 735 Motherwell Building, Regina, Saskatchewan.

(4) Regional Superintendent, 803-9 Confederation Life Building, 457 Main Street, Winnipeg, Manitoba.

(5) Regional Superintendent, 4th Floor, Booth Building, 165 Sparks Street, Ottawa, Ontario.

(6) Zone Supervisor of Nursing, Box 493, North Bay, Ontario.

(7) Zone Superintendent of Indian Health Services, P.O. Box 430, Upper Town, 3 Buade Street, Quebec, 4, P.Q.

(or) Chief, Personnel Division,

Department of National Health and Welfare, Ottawa, Ontario.

Director of Nursing for modern non-profit, J.C.A.H. Accredited 125-bed General Hospital. Downriver area, Detroit, Michigan. $8,000 - $10,000 yearly, depending on qualifications. Liberal personnel policies, unusual opportunity. Approved residency program; staff, board certified specialists. Progressive expanding organization. Emphasis on postgraduate education. Experience in Nursing Service, Supervision & Administration preferred; Master's or Bachelor's Degree required. Forward complete details to Box K, The Canadian Nurse Journal, 1522 Sherbrooke Street West, Montreal 25, Quebec.

Assistant Head Nurses: excellent personnel policies. Apply Director, Shriners' Hospital for Crippled Children, 1529 Cedar Avenue, Montreal, Quebec.

Registered General Duty Nurses for 28-bed General Hospital, 45-mi. from centre of Montreal with excellent bus service. Gross salary $250 with full maintenance in nurses' home at $35; 3 increases at 6-mo. intervals to $265; 44-hr. wk., 8-hr. rotating shifts; 1-mo. annual vacation; 7 statutory holidays: 2-wk. sick leave, Blue Cross paid. Apply: Mrs. D. Hawley, R.N., County Hospital, Huntingdon, Quebec.

SASKATCHEWAN

Matron (1) for 17-bed hospital situated in southern Saskatchewan, only 20-mi. from U.S.A. Starting salary $340 per mo. with increments every 6-mo., 40-hr. wk. & 3-wk. vacation with pay. Applicants should be 30 years of age & have Supervisory experience. If interested, please write to: Mrs. B. McClement (Matron) or Mr. I. Antonichuk (Manager) at Bienfait Coalfields Union Hospital, Bienfait, Saskatchewan.

Registered Nurses for Fort Qu'Appelle Sanatorium. Initial salary: $280 per mo. with semi-annual increments. Recognition for experience. 40-hr. wk., 4-wk. paid annual vacation, 10 statutory days. Sick benefits & superannuation plans in effect. Room, board & laundry $37.50 per mo. Apply: Superintendent of Nurses, Fort San, Saskatchewan.

Registered Nurses immediately (2) for 50-bed hospital. Salary $275 per mo., 40-hr. wk., no split shifts. $10 extra for night shift, comfortable residence. Good location with excellent bus & rail service. Apply to: Matron, Union Hospital, Rosetown, Saskatchewan.

Graduate Nurse (1) for 8-bed hospital in southern Saskatchewan. Starting salary $280 less $35 maintenance. 40-hr. work wk., 3-wk. vacation, plus statutory holidays. Apply to: Mrs. D. L. Knops, Secretary-Treasurer, Union Hospital, Rockglen, Saskatchewan.

U.S.A.

Registered Nurses for modern 374-bed JCAH fully accredited General Hospital. Located on beautiful San Francisco Peninsula, 20-min. drive from the heart of the city. Openings in all services. Excellent personnel policies. Many extra benefits & opportunities for advancement. Top salaries. Apply: Personnel Director, Peninsula Hospital, 1783 El Camino Real, Burlingame, California.

Registered Nurses, (eligible for California registration) for new 254-bed JCAH approved district hospital, San Francisco Bay area. Positions available in surgery, Gyn., O.B., pediatrics & medicine. **Staff Nurses** entrance salary $345 with range to $385 per mo. Supervisory positions at increased rate. Special area & evening differential paid. Free Blue Cross hospitalization & surgical coverage with liberal personnel policies & fringe benefits. Uniforms laundered free. Excellent modern housing, schools & colleges. Apply: Director of Nursing, Eden Hospital, 20103 Lake Chabot Road, Castro Valley, California.

Registered Nurses for 440-bed modern, progressive hospital. Starting salary $355 per mo. $25 P.M. & night differential. $25 additional for surgery. Tenure salary increases. Liberal vacation plan. 7 pd. holidays, 40-hr. wk. Social security, hospitalization insurance & retirement program. Write: Personnel Office, Sutter Community Hospitals, 2820-L Street, Sacramento, California.

Registered Nurses General Duty for 230-bed approved teaching hospital, resort city. Salary $330 plus $22.50 shift differential, provision for housing allowance. Apply: Director of Nursing, Cottage Hospital, Santa Barbara, California.

Registered Nurses for Operating Room, Delivery, Nursery — all shifts. Starting salary $340 per mo., liberal shift differential, 9 paid holidays, insurance, sick leave & vacation. Contact: Director of Nurses, Washington Township Hospital, 2000 Mowry Avenue, Fremont, California.

Registered General Duty Nurses (2) for small General Hospital. Salary $375 per month. For information write: Box 336, Dos Palos, California or phone Express 2-3266 collect.

General Duty Nurses for large teaching hospital in central California. In-service educational program, college community, good fringe benefits. Salary range $341-$413. Apply: Personnel Director, 732 East Main St., Stockton 2, California.

General Duty Nurses — J.C.A.H. accredited 99-bed hospital midway between Los Angeles & San Francisco. Salary depends upon experience & qualifications. Rooms available in modern nurses' residence $10 per mo., 40-hr. wk., 15 days vacation, liberal sick leave, 12 holidays. Social Security benefits. Write: Superintendent of General Hospital, Tulare, California.

Staff Nurses 600-bed general & tuberculosis teaching institution in central valley City. Accredited State & Junior Colleges in immediate vicinity, liberal personnel policies. Full maintenance available. Write — Director of Nursing Service, Fresno County General Hospital, Fresno 2 California.

REGISTERED NURSES
AND
CERTIFIED NURSING ASSISTANTS

SUNNYBROOK HOSPITAL, TORONTO
DEER LODGE HOSPITAL, WINNIPEG
QUEEN MARY VETERANS HOSPITAL, MONTREAL
WESTMINSTER HOSPITAL, LONDON
LANCASTER HOSPITAL, SAINT JOHN, N.B.
STE. ANNE DE BELLEVUE VETERANS HOSPITAL, P.Q.
SHAUGHNESSY HOSPITAL, VANCOUVER, B.C.

Pension plan; three weeks' paid vacation; three weeks' cumulative sick leave; 5 day week; low cost living in staff residence — for Nurses. Application forms are available at Civil Service Commission Offices, National Employment Offices and main Post Offices.

For further particulars contact the Civil Service Commission Office in the province where the position in which you are interested exists —

ONTARIO — 25 St. Clair Ave. East, Toronto.
MANITOBA — 266 Graham Ave., Winnipeg
NEW BRUNSWICK — Post Office Bldg., Canterbury St., Saint John, N.B.
QUEBEC — 685 Cathcart St., Montreal
BRITISH COLUMBIA — 1110 Georgia St. West, Vancouver, B.C.

VICTORIA HOSPITAL
LONDON, ONTARIO

Modern 900-bed hospital

requires

Registered Nurses for all services

and

Certified Nursing Assistants

40 hour week - pension plan - good salaries and personnel policies.

Apply:

DIRECTOR OF NURSING
VICTORIA HOSPITAL
LONDON, ONTARIO.

REGISTERED NURSES

required for the

GENERAL STAFF

of the

OPERATING ROOM

Salary range $270 - $305

commensurate with experience and qualifications.

Apply

DIRECTOR OF NURSING
McKELLAR GENERAL HOSPITAL
FORT WILLIAM, ONTARIO

REGISTERED NURSES

required

OBSTETRICS

AND

OPERATING ROOM

Good personnel policies

Pension plan & group insurance

Apply:

DIRECTOR OF NURSING
QUEENSWAY GENERAL HOSPITAL
TORONTO 18, ONTARIO

Staff Nurses for 300-bed General Hospital. Attractive personnel policies plus differential for specialties, afternoon & night duty. Opportunities for advanced education. Apply to: Director of Nursing Service, Kaiser Foundation Hospital, Oakland 11, California.

Operating Room Nurses: Salary $340 - $385 upon registration plus $33 shift differential. Time & a half (½) for weekends & holidays. Employee's Health & pension Plans, nurses' residence. Apply: Director of Nursing, Cedars of Lebanon Hospital, Hollywood 29, California.

General Duty Nurses for 50-bed General Hospital located in college town in mountainous portion of Colorado. Salary $300 per mo. with periodic increases. Fringe benefits include meals, uniform laundry, sick leave & vacation. Registration requires 3-mo. training in Psychiatry & Pediatrics on a segregated service. Contact: Superintendent, Community Hospital, Alamosa, Colorado.

Registered General Duty Nurses for 154-bed General Hospital with expansion program under way. Along the shores of Lake Michigan, 25 mi. from Chicago. Salary: $365 for days, $395 for evenings, $385 for nights, 5 day wk. Good personnel policies. Apply Personnel Director, Highland Park Hospital Foundation, 718 Glenview Ave., Highland Park, Ill.

General Duty Nurses for 320-bed General Hospital. Only a few blocks from Lake Michigan Beach & Lincoln Park; near Chicago Loop. Hospital accredited by J.C.A.H. & school of nursing accredited by N.L.N. Apartments available close to hospital. Liberal personnel policies. Must be eligible for Ill. registration; openings on all shifts. Write: Director of Nursing, Augustana Hospital, 411 W. Dickens Ave., Chicago 14, Illinois.

Graduate Staff Nurses (Opportunities in the United States) for well equipped 426-bed non-sectarian General Hospital affiliated with Medical School. Monthly salary rates: $370-$400 days; & $400-$430 afternoon & nights, 40-hr. wk., comfortable, low cost living accommodations in residence. Write to: Director of Nursing Service, Dept. C.J.N., Mount Sinai Medical Center, 2750 West 15th. Place, Chicago 8, Illinois.

Operating Room Nurses (Days & P.M.) 154-bed General Hospital located in beautiful residential suburb along the north shore of Lake Michigan just north of Chicago. Modern ranch style nurses' homes with attractively furnished private bedrooms. 40-hr. wk. Salary: $390 days, $420 evenings, other employee benefits. Contact: Personnel Director, Highland Park Hospital Foundation, Highland Park, Illinois.

Nurses in obstetrics, pediatrics, medicine & surgical nursing. We invite inquiries from all Canadian Nurses considering employment in the United States. For full particulars, write: Director of Nursing Service, Indiana University Medical Center, 1100 West Michigan Street, Indianapolis 7, Indiana.

Registered Nurses (Staff Nurse positions available). Starting salary $300 - $450 per mo., liberal vacation, low cost hospitalization plan, group life insurance, sick leave & other benefits. Opportunity to gain clinical experience in psychiatric nursing; orientation, in-service training & other learning experiences offered during the year. Apply: Director of Nursing Service, The C. F. Menninger Memorial Hospital, Box 829, Topeka, Kansas.

Registered Nurses — Salary open, commensurate with experience, differential for evenings & night service. Openings in Obstetrical & Medical-Surgical areas. Must be eligible for registration in the State of Michigan. Apply to: Personnel Department, Woman's Hospital, 432 E. Hancock Avenue, Detroit 1, Michigan.

Registered Nurses: Transportation Paid via 1st class air to Albuquerque & return in exchange for 1-yr. employment contract. Come to New Mexico, "Land of Enchantment", largest private hospital in state - General Hospital, sanatorium & geriatric units, building program, in-service education. Vacancies for staff duty, no rotation of shift, salary $300/mo. to start, $15 differential for evenings & nights. Write or call: Mrs. Emily J. Tuttle, Director of Nursing, Presbyterian Hospital Center, 1012 Gold Avenue, S.E., Albuquerque, New Mexico, Phone Chapel 3-5611.

Graduate Nurses for 450-bed non-sectarian acute General Hospital with NLN fully accredited school of nursing. Liberal personnel policies include tuition aid for study at Western Reserve University. Opening of new main building has created attractive positions for Staff Nurses in medical, surgical, obstetric & pediatric divisions. Apartments available in immediate neighborhood. Apply: Miss Louise Harrison, Director of Nursing Service, Mount Sinai Hospital, 1800 East 105th. Street, Cleveland 6, Ohio.

Registered Nurses (Scenic Oregon, vacation playground, skiing, swimming, boating & cultural events) for 295-bed teaching unit on campus of University of Oregon medical school. Salary to start: $339. Pay differential for nights & evenings. Liberal policy for advancement, vacations, sick leave, holidays. Apply: Multnomah Hospital, Portland 1, Oregon.

Staff Nurses (All Services) for air-conditioned teaching hospital. Base salary — rotation: $292 per mo.; evenings or night: $305 per mo. Good personnel policies. Apply: Director Nursing Service, University of Texas Medical Branch, Galveston, Texas.

SUBURBAN TORONTO

GRADUATE NURSES & CERTIFIED NURSING ASSISTANTS

Are invited to enquire re: employment opportunities in a well staffed new 125 bed hospital in suburban west Toronto. General duty salary range: $270-$320 per mo. Certified Nursing Assistants $200-$220 per mo. 5 day week. Residence accommodation optional. Personnel manual forwarded on request. Enquire to:

DIRECTOR OF NURSING, HUMBER MEMORIAL HOSPITAL, 200 CHURCH STREET, WESTON, TORONTO 15, ONTARIO — CH 4-5551

REGISTERED NURSES

FOR THE OPERATING ROOM, OBSTETRICAL AND MEDICAL SURGICAL UNITS OF A 350-BED GENERAL HOSPITAL

Gross salary $270 - $310 per month if registered in Ontario.
Differential of $10 for evening and night duty.
40-hour week. Sick leave cumulative to 30 days.
3 weeks vacation and eight statutory holidays.

Apply:

DIRECTOR OF NURSING SERVICES,
METROPOLITAN GENERAL HOSPITAL, WINDSOR, ONTARIO

GENERAL DUTY NURSES

FOR ALL DEPARTMENTS

Gross salary $276 monthly ($127 bi-weekly) with annual increment $10 monthly ($4.60 bi-weekly) for three years, if registered in Ontario; $256 monthly ($117.80) bi-weekly until registered. Rotating periods of duty, 40-hr. per wk., 8 statutory holidays. 14-days vacation & 12 working days leave for illness with pay after 1-yr. Pension plan available. Ontario Hospital Insurance with Blue Cross supplemental & Physicians' Services Incorporated, partial payment by hospital.

APPLY

DIRECTOR OF NURSING, GENERAL HOSPITAL, OSHAWA, ONTARIO.

THE PETERBOROUGH CIVIC HOSPITAL

REQUIRES

GENERAL DUTY STAFF

OPERATING ROOM STAFF

For further information write:

THE DIRECTOR OF NURSING
PETERBOROUGH CIVIC HOSPITAL, PETERBOROUGH, ONTARIO

ENGLAND

Plastic Surgery, Jaw Injuries & Burns Centre, St. Lawrence Hospital, Chepstow, Mon. England. (127-Plastic Surgery, 50-Orthopedic beds). 6-mo. postgraduate course on Plastic Surgery for Canadian trained nurses commences October 1st. Post provides opportunity of gaining further experience & seeing something of England. Full national nurses' salary paid. Good knowledge of English essential & must pay own fare to England. This post provides an opportunity for those who wish to take a working holiday with pay. Write quoting 2 references to T. A. Jones, Group Secretary, 64 Cardiff Road, Newport, Mon. England.

ALBERTA

Nurses for General Duty (2) in 29-bed hospital near summer resort. Salary $270 per mo. Excellent residence. Apply: Matron, Municipal Hospital, Eckville, Alberta.

Science & Clinical Instructor for school of nursing, one (1) class yearly. Registered Nurses for General Duty. Apply to: Director of Nursing, St. Joseph's General Hospital, Vegreville, Alberta.

BRITISH COLUMBIA

General Duty Nurses for 25-bed hospital, 35-mi. Vancouver, on coast. Close to Garibaldi Park Ski-ing lodge. 1-hr. to city, bus & train service. Salary BCRN $285 - $359 (4th. yr.) non-BCRN $270 - $282 (1st. yr.) Excellent personnel policies. Apply: Director of Nursing, General Hospital, Squamish, British Columbia.

Graduate Nurses for 60-bed modern hospital in resort area on Vancouver Island. R.N. basic $285 with yearly increments according to RNABC personnel policies. Enquiries: Director of Nursing, Campbell River & District General Hospital, Campbell River, British Columbia.

MANITOBA

Registered Nurses (2) for small modern hospital situated in the Whiteshell district of Manitoba. Excellent bus & train services to Winnipeg & Kenora. **One (1) Registered Nurse preferably with O.R. experience.** Starting salary $295 with semi-annual increases of $5.00, 1-mo. vacation after 1-yr., 8-statutory holidays. Apply: Matron, District Hospital, Whitemouth, Manitoba.

ONTARIO

Director of Nursing & Assistant to Administrator — for 60-bed hospital serving 12,000 area Central Ontario. Here is an opportunity for a qualified nursing administrator to widen her field into full administration in hospital in small town. Studies under way for expansion of services & rebuilding. In application give experience, salary requirements & date of commencement, in confidence, to the Secretary of the Board, Willett Hospital, Paris, Ontario.

Supervisor of Nursing for modern 42-bed hospital. Residence accommodation available. State experience & salary requested. Direct enquiries to: The Administrator, General Hospital, P.O. Box 909, Sioux Lookout, Ontario.

Instructor for Certified Nursing Assistant Course. Training program is 10-months. 100-bed modern hospital. **Dietitian** for 100-bed modern hospital. Excellent personnel policies & salary scale, pension plan. **Physiotherapist** for 100-bed modern hospital. Duties to commence September 1, 1960. Apply to: Sister Superior, St. Vincent de Paul Hospital, Brockville, Ontario.

Instructor in July to organize & teach new C.N.A. Course commencing September, 5-day 40-hr. wk., residence available. Apply: Director of Nursing, St. Andrews Hospital, Midland, Ontario.

Registered Nurses for General Duty for 15-bed hospital in Red Lake Area. Duties to commence in July, 1960. Salary $300 per mo., maintenance in new residence $30. 4-wk. vacation after 1-yr., transportation expense 1 way repaid after 6 mo. Apply with full particulars to: The Matron, Margaret Cochenour Memorial Hospital, Cochenour, Ontario.

Public Health Nurse (Qualified) Position open in a completely generalized program. Salary range, pension plan & other personnel policies given on request. Applicant must have car. Apply to: Dr. W. H. Cross, Muskoka District Health Unit, Bracebridge, Ontario.

QUEBEC

General Duty Nurse for new modern 24-bed hospital located in centre of Gaspe Peninsula to be opened in August. Working conditions in accordance with Quebec Association of Nurses standards. 44-hr. wk., excellent recreation facilities including indoor swimming & artificial ice. Reply stating training & experience to Box L, the Canadian Nurse Journal, 1522 Sherbrooke Street West, Montreal 25, Quebec.

Registered Laboratory Technician for new modern 24-bed hospital located in centre of Gaspe Peninsula, excellent recreation facilities including indoor swimming & artificial ice. Salary commensurate with qualifications. Reply stating training & experience to: Box L, The Canadian Nurse Journal, 1522 Sherbrooke Street west, Montreal 25, Quebec.

SASKATCHEWAN

General Duty Nurses for 14-bed Elrose Union Hospital. Salary $280 with yearly increments full maintenance in residence for $34.50, 40-hr. wk. Apply: J. V. Nouch, Elrose, Saskatchewan.

NOTRE DAME HOSPITAL OF MONTREAL

NURSES NEEDED

Salary, according to qualifications: $57.00 - $90.00 per week.
Evening differential: $7.00 per week. — Night differential: $5.00 per week.
Increases: After 6 months, 1 year, 2 years. Pension Fund.
Free: Two meals daily — Laundering of uniforms.
Statutory holidays - 2; Paid sick time - 2 weeks (after 1 year)
Paid vacation: 3 weeks after 1 year.
Opportunities for promotion — Inservice education program.

For further information, write to:

LA DIRECTRICE DU NURSING — HOPITAL NOTRE-DAME — MONTREAL

JEWISH GENERAL HOSPITAL

MONTREAL, QUEBEC

Completion of expansion program makes available attractive positions for Registered Nurses for Administration and General Duty and also for Certified Nursing Assistants. Excellent personnel policies. Salary in accordance with The Association of Nurses of the Province of Quebec recommendations and commensurate with experience and education. Residence accommodation available.

For further information, please write:

DIRECTOR OF NURSING, JEWISH GENERAL HOSPITAL
3755 COTE ST. CATHERINE ROAD, MONTREAL, QUEBEC

CLASSROOM & CLINICAL INSTRUCTORS
GENERAL STAFF NURSES

required

The General Hospital of Port Arthur

Salary schedule in conformity with R.N.A.O. recommendations.
Partial fare refund after 1 yr. in service.

WRITE:

DIRECTOR OF NURSING,
GENERAL HOSPITAL OF PORT ARTHUR, PORT ARTHUR, ONTARIO.

REGISTERED NURSES
NURSING ASSISTANTS

Required for all departments in new 160-bed hospital, centrally located between Toronto and Hamilton, in a very progressive community.

Good salary and personnel policies, pension plan, 40-hour week.

Apply stating age, qualifications to:

DIRECTOR OF NURSING,
OAKVILLE-TRAFALGAR MEMORIAL HOSPITAL, OAKVILLE, ONTARIO

THE ROYAL ALEXANDRA HOSPITAL

EDMONTON, ALBERTA

Requires

General Duty Nurses for Medical, Surgical, Obstetrical and Pediatric Services and for the Operating Room.

Minimum salary $270 per mo. with Alberta Registration.

Good personnel policies.

Apply to:

DIRECTOR OF NURSING,
ROYAL ALEXANDRA HOSPITAL,
EDMONTON, ALBERTA.

DIRECTOR OF NURSING

REQUIRED FOR

160-bed General Hospital

Please reply giving full particulars, including salary expected, to the:

Administrator
KIRKLAND AND DISTRICT HOSPITAL,
KIRKLAND LAKE,
ONTARIO

GENERAL DUTY NURSE

Graduate Nurse, Ontario registration, for general duties in field hospital at Little Long Rapids. This project is located 40 miles north of Kapuskasing and is accessible by rail. Hospital residence.

Write giving full details of education and experience to:—

SUPERVISOR, EMPLOYMENT SERVICES
ONTARIO HYDRO
620 UNIVERSITY AVENUE
TORONTO, ONTARIO.

REGISTERED NURSES AS FLOOR SUPERVISORS

in Geriatric Institution near New York City. Starting salary $4,300 per annum, 37½-hour week plus fringe benefits totalling $700, includes 4 weeks paid vacation, 12 days paid sick leave, 7 paid holidays, Xmas bonus of 1 week's salary. No deduction for meals, residential accommodations $200 year.

Write:

EXECUTIVE DIRECTOR,
DAUGHTERS OF MIRIAM,
CLIFTON, NEW JERSEY.

U.S.A.

Registered Nurse — Immediate positions available in medical-surgical, obstetrical, pediatrics & operating room units of modern, non-profit, J.C.A.H. accredited 125-bed General Hospital located in beautiful suburban area just 20-min. from downtown Detroit. Progressive, expanding organization with liberal personnel policies & in-service education program. Salary commensurate with experience with differential for afternoon & evening shifts. Apply: Director of Nursing, The Lynn Hospital, Lincoln Park, Michigan.

BRITISH COLUMBIA

General Duty Nurses for R.W. Large Memorial Hospital of the United Church of Canada, at Bella Bella, B.C. 300-mi. north of Vancouver on the B.C. coast. Salary $285 per mo., less $50 for board, room & laundry of uniforms. 2 annual increments of $5.00 per mo., sick time — 1½ days per mo., cumulative, 1-mo. annual holiday, plus 10 days in lieu of statutory holidays. Transportation to Bella Bella refunded after 1-yr. Apply to: Matron, Bella Bella, British Columbia.

Graduate Nurses for General Duty in B.C. hospital. Modern nurses' residence, medical plan (M.S.A.) for staff. Salary above standard with increment. Full amenities of country town, surrounded by scenic grandeur. Excellent transportation, 4-hrs. from Vancouver. Apply giving full qualifications, to: Administrator, St. Bartholomew's Hospital, Lytton, British Columbia.

PUBLIC HEALTH NURSES

for

generalized program

in

Seaway Development Area

usual benefits, pension plan, allowance for experience

apply to:

DR. PAUL S. deGROSBOIS, M.O.H.
HEALTH UNIT,
26 PITT STREET, CORNWALL, ONTARIO.

REGISTERED NURSES REQUIRED

(General Duty)

Modern 52-bed hospital 50 miles from Ottawa in the heart of holiday resort area has openings. Commencing salary $240 per month ($10 extra night duty two weeks) all statutory holidays from employment date, three weeks annual vacation, straight 8-hour day, 5-day (40-hour) week.

Private accommodation in luxurious new residence with full board and all facilities including laundry. $25 per month only.

Apply

DIRECTOR OF NURSING,
PONTIAC COMMUNITY HOSPITAL
SHAWVILLE, QUEBEC

OPERATING ROOM SUPERVISOR

and

GENERAL DUTY NURSES

for 60-bed General Hospital 22 miles from London, excellent personnel policies, accommodation available in residence.

Apply to:

DIRECTOR OF NURSING,
STRATHROY GENERAL HOSPITAL,
STRATHROY, ONTARIO.

WANTED

by the

City of Hamilton

PUBLIC HEALTH NURSE

Must be a graduate nurse and should have a public health certificate. 5 day, 36¼ hour week. Maximum salary $4,314. Generous vacation, sick leave and pension plan. Starting salary commensurate with previous experience.

Apply to:

DIRECTOR OF PERSONNEL
CITY HALL, HAMILTON, ONTARIO

THE OTTAWA CIVIC HOSPITAL

WITH

A capacity of 1200 beds including
A new modern 300 bed unit

OFFERS

An interesting variety of experiences

Good personnel policies

Salary allowance for experience and postgraduate courses.

Apply:

DIRECTOR OF NURSING,
OTTAWA CIVIC HOSPITAL,
OTTAWA, ONTARIO.

NURSES

REQUIRED AT

ROSEWAY, HOSPITAL

SHELBURNE, N.S.

Superintendent of Nurses	$4,200 - $4,950
Nursing Supervisor	$3,240 - $3,750
Operating Room Nurse	$3,120 - $3,600
Staff Nurses	$2,880 - $3,360

Full Civil Service benefits.

APPLY TO:

NOVA SCOTIA CIVIL SERVICE COMMISSION
P.O. BOX 943, HALIFAX, NOVA SCOTIA

PUBLIC HEALTH NURSE

REQUIRED FOR

a rural urban district in a northwestern Ontario Health Unit. Nurse will live in a city of 45,000 population. Hospital plan, P.S.I., Pension Plan, sick leave 1½ days monthly, 4 weeks vacation, generous car allowance. Salary commensurate with experience.

Apply to:

DR. W. C. MacPHERSON, DIRECTOR
PORT ARTHUR & DISTRICT HEALTH UNIT
93 BALSAM ST., PORT ARTHUR, ONTARIO

OPERATING ROOM SUPERVISOR

required by

DEPARTMENT OF VETERANS AFFAIRS
MONTREAL, P.Q.

$3,900 - $4,560

Candidates must be graduate nurses and registered in a province of Canada, must possess a certificate of a completed course of recognized standing in operating room techniques and have several years of experience (some supervisory) in an operating room.

For details, write to

CIVIL SERVICE COMMISSION, OTTAWA
Please ask for Circular 60-820.